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Review of Matters Related to the Death of Hospitalman (HN) Christopher Purcell, U.S. Navy

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The Department of Defense Office of the Deputy Inspector General for Policy and Oversight, Assistant Inspector General for Investigative Policy and Oversight prepared this report. If you have questions or would like to obtain additional copies of the final report, contact Mr. Scott Russell at (703) 604-8718 (DSN 664-8718).

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LIST OF ACRONYMS

Acronym	Refers to:
BPD	Brunswick Police Department
CA	Convening Authority
CDI	Command Directed Investigation
CID	Criminal Investigation Division
CO	Commanding Officer
DCIO	Defense Criminal Investigative Organization
DoDSER	Department of Defense Suicide Event Report
DoD	Department of Defense
DoD IG	Department of Defense Inspector General
DoN	Department of the Navy
FTO	Field Training Officer
FOIA	Freedom of Information Act
HN	Hospitalman
IG	Inspector General
IO	Investigating Officer
JAG	Judge Advocate General
JAGMAN	Manual of the Judge Advocate General
LOD	Line of Duty Investigation
MA	Master at Arms
MCRT	Major Crimes Response Team
MIDLANT	Navy Region Mid-Atlantic
MILPERSMAN	Military Personnel Manual
NASB	Naval Air Station Brunswick
NCIS	Naval Criminal Investigative Service
NHCNE	Naval Health Clinic New England
NAVPERS	Navy Personnel
NJP	Non-Judicial Punishment
NSF	Naval Security Forces
OAFME	Office of Armed Forces Medical Examiner
OGC	Office of General Counsel
OPNAVINST	Operational Navy Instruction
RLSO	Regional Legal Services Office(r)
SECNAVINST	Secretary of Navy Instruction
SJA	Staff Judge Advocate

INSPECTOR GENERAL
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OCT 27 2010

MEMORANDUM FOR ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND RESERVE AFFAIRS)
NAVAL INSPECTOR GENERAL
COMMANDER, NAVY REGION MID-ATLANTIC
CHIEF, BUREAU OF MEDICINE & SURGERY
DIRECTOR, NAVAL CRIMINAL INVESTIGATIVE SERVICE

SUBJECT: Review of Matters Related to the Death of Hospitalman (HN) Christopher Purcell, U.S. Navy (Report No. IPO2010E002)

This final report is provided for your review and additional comment. Management comments on the draft report were considered in preparing the final report and are addressed in detail in the final report. Management comments are also included in the final report as Appendix C.

DoD Directive 7650.3 requires that all recommendations be resolved promptly. The management comments provided were responsive to our recommendation. We request you provide additional comments on our recommendation as soon as you complete reporting additional investigative activity. Your comments should be submitted electronically to scott.russell@dodig.mil.

We appreciate the courtesies extended to our staff throughout this review. For additional information on this report, please contact Mr. Scott Russell, (703) 604-8718; 664-8718 (DSN). You may also contact Mr. John Perryman, Director of Oversight, at (703) 604-8765; 664-8765 (DSN).

Randolph R. Stone, SES
Deputy Inspector General
Policy and Oversight

Attachment
Final Report IPO2010E002

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REVIEW OF MATTERS RELATED TO THE DEATH OF HOSPITALMAN (HN) CHRISTOPHER PURCELL, U.S. NAVY

I. INTRODUCTION AND SUMMARY

We initiated this review on March 9, 2009, in response to a request from Representative Mark Steven Kirk (R – IL) on behalf of the parents of HN Christopher Purcell following his suicide on January 27, 2008, while in custody of Navy law enforcement officials at Naval Air Station Brunswick (NASB), Brunswick, ME. Mr. and Mrs. Purcell questioned: (1) no policies or procedures changed in response to the incident; (2) each of the first responders retained their rank and still serve in the same capacity they did that evening; (3) the first responders were not held accountable, nor is the Navy showing accountability, and (4) the Navy closed the case in September 2008 and "will not tell us anything else." Representative Kirk wrote to DoD Legislative Affairs, and they routed the matter to DoD Inspector General (IG) for action.

In completing our review, we focused on these specific questions:

- **Did Department of Navy (DoN) officials investigate the incident in accordance with DoD and DoN guidance?**
- **Did DoN officials determine whether law enforcement training or qualifications were factors that contributed to Purcell's death while in custody?**
- **Did DoN officials implement adequate corrective measures to prevent future occurrences?**
- **Did DoN officials properly disclose information in response to Mr. Purcell's Freedom of Information Act (FOIA) request?**

During our work, we reviewed the facts and circumstances of the incident, and reviewed the investigations completed by:

- Naval Criminal Investigative Service (NCIS);
- Commanding Officer (CO), Naval Health Clinic New England (NHCNE), and
- CO, NASB.

We also interviewed sailors, civilian police officers, NCIS agents and supervisors, the investigating officers (IOs), and other witnesses.

We found NCIS concluded the cause of HN Purcell's death was a gunshot wound to the chest and the manner of his death was suicide.[1] NCIS conducted their investigation in accordance with the DoD, DoN and NCIS standards.

[1] We identified instances where NCIS agents did not fully comply with NCIS internal investigative procedures. These deficiencies did not materially impact their overall conclusion, and therefore, are not reflected in this report. We provided a memorandum documenting these deficiencies to NCIS senior management.

We found the Line of Duty (LOD)[2] IO determined HN Purcell's death was in the line of duty. However, the LOD was inadequate because the IO failed to recognize the significance of the information he collected and how it related to suicidal behavior warning signs. The IO also did not investigate command actions taken in response to those warnings.

We determined the CO, NASB responded to HN Purcell's death by ordering a Command Directed Investigation (CDI). We determined the CDI IO investigated the complete security response including pertinent policies, procedures, and training requirements in compliance with the JAGMAN Instructions. We concurred with the CDI IO's findings regarding the actions of the police officers and MAs who were involved in the incident.

The CDI investigation and our review both determined the NASB training program adequately trained the responding police officers and the responding officers were qualified to perform their law enforcement duties in accordance with departmental policies.

We determined DoN officials implemented corrective measures to prevent recurrences similar to HN Purcell's death. The CO, NASB initiated the CDI despite no regulatory requirement to do so, and he ensured recommendations were implemented. The recommendations were realistic and based upon DoD and DoN standards.

We concluded DoN officials disclosed information in response to Mr. Purcell's FOIA request; all disclosures made to Mr. Purcell conformed to the Privacy Act and FOIA.

We recommended the following:

- We recommend Department of Navy Bureau of Medicine and Surgery correct the deficiencies in the line of duty investigation, including thoroughly documenting and supporting findings of facts, investigating the command's response to suicide warning signs displayed by Hospitalman Purcell and apparently recognized by others, and making recommendations as originally directed by the convening authority.

This report sets forth our findings and conclusions based on a preponderance of the evidence.

II. THE INCIDENT

About 9:07 PM, January 27, 2008, a Navy Hospital Corpsman, assigned to Naval Branch Health Clinic, NASB, Brunswick, ME, contacted the NASB police and reported a possible suicidal individual at Bachelor Housing, Building 731, Room 9A (Building 731 is a two-story condominium with 10 units configured to house two sailors per unit.). About a minute later, the Corpsman called back stating HN Purcell was threatening to harm himself with a weapon.

[2] JAGMAN Instructions 5800.7D, Section 0220, states "A line of duty determination is required whenever an active duty service member of the Naval service dies, in order to make decisions concerning eligibility and annuity calculations under the Uniformed Services Survivor Benefit Program."

About 9:10 PM, January 27, 2008, the NASB police dispatched police units. The dispatcher also notified the NASB Emergency Medical Technician, who responded to the scene.

The police found the front door to Room 9A open. They entered, and identified HN Purcell seated at his computer desk. The officers observed several empty and one partially full alcoholic beverage bottles, an empty handgun case, and an open box of ammunition with between one and three rounds missing. HN Purcell told the officers he had given the weapon to a friend. Another police unit comprised of an active duty sailor (Master at Arms (MA)) and a civilian officer arrived shortly after the first units. The responding sailor recognized the need to search more thoroughly for the weapon, and asked HN Purcell to accompany him outside while the other responding officers searched the remaining areas of HN Purcell's room. Their search did not find the weapon. During the IO's CDI, some of the officers stated they performed "sensory" searches of HN Purcell and did not find a weapon on his person.

While the sailor and HN Purcell were outside, a second sailor (MA), who was off-duty, arrived at the scene. He had earlier completed his shift and had turned in his weapon. After speaking with the initial responding sailor, the second sailor directed him to place HN Purcell in hand irons. Once confronted, HN Purcell resisted. Approximately five officers, including the two sailors, subdued HN Purcell and placed him in hand irons.

Due to the cold temperature, HN Purcell was brought indoors to his kitchen. While there, the off-duty sailor asked HN Purcell if he wanted anything to drink or if he had to go to the bathroom. After HN Purcell replied he wanted to use the bathroom, the off-duty sailor directed an officer remove one of HN Purcell's hand irons and to accompany HN Purcell to the bathroom. When HN Purcell requested no one from Security accompany him, the NASB Emergency Medical Technician volunteered and accompanied HN Purcell into the bathroom. Without the NASB Emergency Medical Technician's knowledge, while standing before the toilet, HN Purcell removed a handgun (Ruger, .357 magnum caliber) from his person and shot himself in the chest. HN Purcell was later pronounced dead at the scene.

NASB dispatch notified the NASB Criminal Investigation Division (CID), and the Brunswick Police Department (BPD).[3] Working concurrently, the CID and BPD, obtained photographs and began interviewing witnesses. About 10:30 PM, January 27, 2008, NASB police dispatch notified NCIS. NCIS agents responded to the scene and assumed primary investigative jurisdiction.

The Office of the Armed Forces Medical Examiner (OAFME)[4] conducted an autopsy on HN Purcell and determined the cause of death was a gunshot wound to the chest, and the manner of death was suicide. The NCIS investigation concluded the death was a suicide. NCIS completed its investigation on September 11, 2008.

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[3] There was a Memorandum of Understanding between NASB and BPD, for BPD to respond to NASB during certain law enforcement matters.

[4] DoD Directive 6010.16 states OAFME, "An autopsy shall be performed on the remains of any person who dies while on active military duty, when necessary to determine the cause and manner of death (such as sudden, unexpected death, homicide or suicide), to secure information for completion of military records or to protect the welfare of the military community.

On January 29, 2008, the CO, NHCNE appointed an IO to conduct a LOD investigation in accordance with JAGMAN Chapter II, "into the circumstances of the death of HN Christopher Purcell." The CO, NHCNE instructed the IO to "focus your attention on HN Purcell's duty status on 27 January 2008, his recent medical history and treatment, and the events which lead to HN Purcell's apprehension by NAS Brunswick Security Personnel on 27 January 2008." The CO, NHCNE directed the IO to "report his findings, including personnel contacted, materials reviewed, summary of findings, and recommended courses of action by 29 February 2008," and to provide a "recommendation for a line of duty/misconduct determination." The IO completed his LOD on March 17, 2008. He concluded "…HN Purcell's death was in the Line of Duty and his death was not due to his own misconduct but was a result of his longstanding mental illness."

On January 30, 2008, the CO, NASB, appointed an IO to conduct a CDI "into the facts and circumstances surrounding the NAS Brunswick Security response at the NASB Bachelor Housing on the evening of 27 January 2008," instructing the IO to "[I]nvestigate the complete security response in the light of the existing pertinent policies, procedures, and training requirements at the time of this incident." The IO completed his inquiry on February 29, 2008, concluding "[T]hrough neglect and culpable inefficiency by NAS Brunswick security personnel, HN Purcell was able to affect his suicide with a firearm while in their custody."

III. SCOPE

Our review focused on whether DoN officials adequately investigated the NASB law enforcement response to complaints HN Purcell was suicidal and had a weapon, and whether DoN officials took appropriate actions to correct deficiencies identified in the response.

We examined whether NCIS thoroughly investigated the incident. We addressed the adequacy of the LOD investigation, i.e., whether the IO adequately addressed the actions of the chain of command, co-workers, and medical personnel in responding to HN Purcell's behavior prior to the incident. We also examined whether training of the first responders was a contributing factor, and we looked at whether corrective measures undertaken should prevent such incidents from occurring again. Finally we considered whether DoN officials properly responded to Mr. Purcell's FOIA requests.

Additionally, the evaluation addressed the adequacy of the CDI, i.e., whether the IO adequately addressed the actions of the responding NASB law enforcement personnel that led to HN Purcell's suicide, to include: whether responsible officials complied with applicable DoD guidance and DoN regulations regarding first response to crisis incidents (including possible suicides involving weapons), proper apprehension and restraint, and searches incident to apprehension or detention.

We interviewed 49 witnesses, including: NCIS special agents and supervisors; NASB public safety managers; numerous NASB police officers, the two active duty sailors (MA's), the two IOs; the CO, NASB; the supporting Navy Judge Advocates; Navy Region Mid-Atlantic (MIDLANT) security officials; Mr. and Mrs. Purcell, and other witnesses. In addition, we reviewed the NCIS report of investigation, the command directed investigation of the law

enforcement response, the line-of-duty investigation and documents associated therewith, as well as relevant e-mail messages and internal documents within the chain of command and similar communications within the DoN.

We reviewed the policies and standards to determine whether responsible Navy officials complied therewith, and whether any systemic issues contributed to the incident.

IV. FINDINGS AND ANALYSIS

1. Did DoN officials investigate the incident in accordance with DoD and DoN guidance?[5]

a. Did NCIS investigate the incident in accordance with DoD and DoN guidance?

NCIS determined HN Purcell's death was a suicide. We examined the NCIS Report of Investigation, analyzed it against the regulatory standards and agreed that NCIS properly concluded HN Purcell's death was a suicide. There was no regulatory requirement for NCIS to investigate the actions of the responding police officers. We identified some administrative and investigative deficiencies and determined the deficiencies did not impact NCIS' investigative conclusion. We did not address the deficiencies in our report, but we detailed them in a memorandum to HQ, NCIS recommending reinforcement of compliance with NCIS internal investigative standards.

Standards

There are three standards which dictate the conduct of NCIS criminal investigations. They include: Department of Defense Instruction (DoDI) 5505.10, "Investigation of Noncombat Deaths of Active Duty Members of the Armed Forces," dated January 31, 1996; Secretary of the Navy Instruction (SECNAVINST) 5430.107, "Mission and Functions of the Naval Criminal Investigative Service," dated December 28, 2005; and Naval Criminal Investigative Service (NCIS) 1, "Administrative" and NCIS 3, "Criminal Investigations." (See Appendix A).

[5] Our evaluation of DoN's response to the HN Purcell incident included the review of three separate and distinct investigations. Per policy, DoN initiated two investigations. The NCIS investigation examined HN Purcell's death per DoD Directive 5505.10 which states, "All noncombat deaths of members of the Armed Forces on active duty, not medically determined to be from natural causes, shall be investigated as potential homicides until evidence establishes otherwise." The second investigation, previously identified as the LOD investigation is required per JAGMAN Instructions 5800.7D, Section 0220. Though not required, DoN initiated a third investigation, previously identified as the CDI, to, "Investigate the complete security response in the light of the existing pertinent policies, procedures, and training requirements at the time of this incident."

Facts

Since NASB was under concurrent Federal and State jurisdiction, the NASB police notified the Brunswick Police Department (BPD) of HN Purcell's death, and they responded. BPD notified the State Medical Examiner and State Police of a death in police custody. The death was also reported to NCIS. At NCIS' request and with BPD's agreement, NCIS assumed primary jurisdiction for the incident. As such, the State Police did not respond.

The initial NCIS response came from Portsmouth, NH. While waiting for NCIS, BPD, with the assistance of NASB Police CID, interviewed and obtained statements from military and civilian witnesses. When NCIS arrived, they were given those statements. NCIS initiated a death investigation on January 28, 2008. The responding NCIS agents stated it took about 2 hours to get to NASB. Both agents indicated the incident was reported to them as a suicide. While responding they alerted the NCIS Northeast Major Crimes Response Team (MCRT) and briefed NCIS supervisors of preliminary information provided about the incident. The MCRT consisting of agents from New London, CT and Newport, RI, arrived the morning of January 28, 2008, and processed the scene. The afternoon of January 28, 2008, a NCIS Forensic Consultant (from HQ, NCIS) processed the remains for physical evidence. On January 29, 2008, the Office of the Armed Forces Medical Examiner (OAFME), Rockville, MD conducted an autopsy. OAFME determined the cause of death was a self-inflicted gunshot wound to the chest, and the manner of death was suicide. NCIS interviewed all responding police officers and witnesses, confirmed HN Purcell purchased a gun from a local gun shop on January 17, 2008, and collected items of evidence later examined by the U.S. Army Criminal Investigation Laboratory, Fort Gillem, GA. Forensic tests concluded the fatal injury came from the gun HN Purcell purchased. Following a Death Review Panel on September 4, 2008, and a Death Review Board on September 10, 2008, the NCIS investigation was closed September 11, 2008. They concluded HN Purcell committed suicide.

We examined the NCIS Report of Investigation, analyzed it against the regulatory standards and determined NCIS properly concluded HN Purcell's death was a suicide. We identified some procedural deficiencies; however, they did not impact their investigative conclusion.[6]

Discussion

DoDI 5505.10, "Investigation of Noncombat Deaths of Active Duty Members of the Armed Forces," requires deaths to be investigated as potential homicides until evidence establishes otherwise. Additionally, it requires each Defense Criminal Investigative Organization to provide military authorities with all information necessary to make command determinations. SECNAVINST 5430.107, "Mission and Functions of the Naval Criminal Investigative Service," mandates NCIS investigates any non-combat death, on or off naval installations, facilities, vessels, or aircraft, where the cause of death cannot be medically attributable to disease or natural causes until criminal causality can be reasonably excluded. NCIS 3, Chapter 30-13 directs NCIS to investigate all suicides by conducting a thorough and

[6] We provided a memorandum to HQ, NCIS identifying the deficiencies, and we recommended reinforcement of compliance with NCIS internal investigative standards.

complete investigation to ensure potential homicides are not "masqueraded as a suicide." We determined NCIS appropriately concluded HN Purcell's death was a suicide. NCIS did not investigate potential malfeasance. On January 29, 2008, responding agents were directed by NCIS headquarters,

> …the principal purpose of the NCIS investigation is not to document the errors made by base security so that administrative action can be taken against them. Although Command may use documentation from the NCIS Death investigation for that purpose, that would be their decision. Again, NCIS [is] not investigating malfeasance of base security.

On interview the responding agents, supervisors and NCIS headquarters senior managers, using their judgment, decided to limit the scope of their investigation to the suicide. We agree with their conclusion HN Purcell's cause of death was a gunshot wound to the chest, and the manner of death was suicide. Though they did not determine the origin of the weapon in their final report, they surmised HN Purcell possessed the gun during the entire incident. Regardless of whether the gun had been concealed on his person or was secreted in the lavatory or elsewhere, NCIS agents conclusively determined the fatal wound was self-inflicted.

b. Did the Commanding Officer, Naval Health Clinic New England investigate the incident in accordance with DoD and DoN guidance?

We found although the IO arrived at the proper determination HN Purcell's death was in the line of duty, his command investigation was inadequate. The IO did not pursue information which was consistent with suicidal behavior warning signs, and he failed to investigate command actions in response to those warnings. The IO documented in his report these behavioral changes as early as 3 months before HN Purcell's death; however, we found he erred when he opined there was no concrete warning or indication that he would take his own life up until the evening of January 27, 2008. Additionally, he did not conduct thorough interviews to obtain details leading up to HN Purcell's death, and he did not properly document information he obtained during those interviews. Further, the CO, NHCNE and the CO, Navy Medicine East failed to comply with the JAGMAN when they endorsed the IO's inadequate investigation.

Standards

JAG Instruction 5800.7D, "Manual of the Judge Advocate General," (JAGMAN) dated June 20, 2007, provides guidance regarding the completion of required line-of-duty death investigations. (See Appendix A).

Facts

On January 29, 2008, the CO, NHCNE appointed the IO, to conduct a line of duty death investigation in accordance with JAGMAN Chapter II, "into the circumstances of the death of HN Christopher Purcell." The CO, NHCNE instructed the IO to "focus your attention on HN Purcell's duty status on 27 January 2008, his recent medical history and treatment, and the events which lead to HN Purcell's apprehension by NAS Brunswick Security Personnel on 27 January 2008."

The CO, NHCNE directed the IO to "report his findings, including personnel contacted, materials reviewed, summary of findings, and recommended courses of action by 29 February 2008," and to provide a "recommendation for a line of duty/misconduct determination." The IO completed his inquiry on March 17, 2008. He concluded ". . . HN Purcell's death was in the Line of Duty and that his death was not due to his own misconduct but was a result of his longstanding mental illness."

The IO's final report contained 22 findings of fact. Per the JAGMAN, each finding must be supported by fact, recorded separately with an enclosure supporting that finding. The IO based his findings on supportable documents which included the NCIS investigation, HN Purcell's medical records, completion of the Department of Defense Suicide Event Report (DoDSER) and other miscellaneous documents. We reviewed the IO's findings of fact in relation to the enclosures he cited, and determined the cited enclosures did not support his findings of fact. On interview, the IO agreed his report contained administrative errors.

The IO did not make recommendations as the CO, NHCNE directed. He concluded his command investigation with only findings of fact and opinions. The IO admitted he failed to make recommendations. On interview, the IO stated,

> You know, I feel bad enough thinking two years later, I should have made some recommendations. Oh God, I didn't know I was supposed to make recommendations. Okay. I don't remember, you know, if that was part of what I was supposed to do. If I'm supposed to do it then I clearly missed the boat on this one. It's just one of those situations that in retrospect, there are a lot of recommendations we could have made. We could have done more training, you know, locally here.

The IO explained this was the first and only command investigation he conducted, and he was unfamiliar with JAGMAN requirements. Upon his appointment, he received the JAGMAN Instruction Handbook which he used to assist him.

The IO admitted there was information he gathered during his investigation which he failed to document in his report. The IO told us he consulted with a Navy medical doctor who reviewed HN Purcell's medical records, the command interview forms, and medical history including HN Purcell's treatment for mental illness as a Navy dependent child and while on active duty and his prescribed medications. The doctor opined HN Purcell suffered from a longstanding mental illness. The IO admitted he based his opinion on that of the doctor. The IO did not document the coordination or attribute that information in his report. He admitted,

> I think that my error in a lot of things should have been documented obviously to those notes because it was already done. So, again, you know, the issue here, I could have done things clearly better as far as how to do this report. Clearly, there's no dispute on that.

Discussion

The IO failed to comply with JAGMAN instructions in completing the LOD investigation. We found the following deficiencies:

Indicators of suicidal behavior and suicide risk. The IO reported there was no concrete warning or indications HN Purcell was suicidal until the day he died. The only suicidal behavior warning sign the IO documented as a finding of fact was "HN Purcell purchased a handgun 10 days prior to his death." Our review of the IO's report revealed the following information:

- According to a co-worker, HN Purcell "showed a lot of depressive signs"; "spent a lot of time listening to music about suicide for hours on end"; "wasn't sleeping at night and when he was sleeping, it was restless"; "He was giving away some personal items"; "sold his 'baby' – motorcycle, claiming he needed money"; "stated he was looking forward to the day his eyes won't open."
- A friend spent an evening with HN Purcell and found him extra quiet and acting odd. When leaving, HN Purcell gave friend a big hug which was odd as it was a long embrace and the friend and HN Purcell had never hugged before.
- HN Purcell's personality changed around October 2007. He was moved from the Immunizations clinic to the Family Practice clinic and was angry over the move. He always wanted to know what was wrong with him and had low self-esteem. He always drank alcohol but after his 21st birthday, HN Purcell wasn't out to get drunk, party and be happy, he was drinking to get rid of some pain. He also began listening to very dark music.
- HN Purcell reportedly felt his visits to Substance Abuse and Rehabilitation Program (SARP) made him "feel like a dirt bag."
- When HN Purcell began drinking he would drink "until he passed out."
- When HN Purcell returned from Thanksgiving, he told a co-worker he had some panic attacks on leave and said he was going to get some help for it.
- HN Purcell asked a co-worker if he had ever thought about suicide.
- A supervisor of HN Purcell was informed by a co-worker who expressed concern that HN Purcell was selling off his possessions.
- A friend of HN Purcell noted a change in HN Purcell's behavior about 3 months before his death. HN Purcell was reportedly kicked out of a club for punching a statue, and he (Purcell) found this entertaining. HN Purcell told this friend he was doing self-destructive things to see if he would get into trouble, like driving his car to the clinic while drunk. The friend reported to HN Purcell's supervisor on two separate occasions that HN Purcell was selling off his possessions and was drinking and sleeping the entire time he was on leave. The supervisor told the friend, "I know what it looks like" but took no action.
- On November 13, 2007, during initial SARP, HN Purcell stated his work performance had suffered due to alcohol use with five drinking binges in the last two weeks.
- HN Purcell expressed strained relationships with friends and a lack of trust and sincerity in relationships; expressed trouble sleeping and a family history of alcoholism and mental illness.

We found the information consistent with the warning signs illustrated in the suicide prevention acrostic (ISPATHWARM) at the Navy's Suicide Prevention Website[7]:

I - Ideation (thoughts of suicide expressed, threatened, written);
S - Substance Abuse (increased or excessive alcohol or drug abuse);
P - Purposelessness (seeing no reason for living or having no sense of meaning or purpose in life);
A - Anxiety (feeling anxious, agitated, frequent nightmares, unable to sleep or sleeping all the time);
T - Trapped (feeling trapped, like there is no way out);
H - Hopelessness (feeling hopeless about self, other, the future);
W - Withdrawal (withdrawing from family, friends, usual activities, society);
A - Anger (feeling rage or uncontrolled anger, seeking revenge for perceived wrongs);
R - Recklessness (acting without regard for consequences, excessively risky behavior);
M - Mood Changes (experiencing dramatic changes in mood).

The IO failed to recognize the information he had gathered as consistent with suicidal behavior warning signs, and he failed to investigate whether command personnel undertook appropriate suicide prevention measures. When challenged, the IO stated,

> Clearly, now I'm thinking back here, knowing that, yes, I mean a lot of these things are risk factors for suicide. It's not concrete, but there's still evidence that says -- was it potentially possible for us to pick up on issues with this guy. And the answer -- I guess the answer is yes.

Interviews not properly documented. The final paragraph in the IO's preliminary statement reflected he consulted 16 named individuals who had information regarding his investigation. We were unable to identify by name throughout his report what information each of these individuals provided. The IO told us some of the individuals just provided "interpretive" help or just "contributed" to his report, and he destroyed any notes and/or information he obtained from those interviews. The IO did not obtain any written testimony, and annotated nine of the interviews mentioned above using a DoDSER command interview form. JAGMAN Section 0214, paragraph (d) states,

> Ordinarily, witnesses should provide statements in informal interviews. They may be required, however, to provide recorded testimony under oath. Probing questions as to 'who,' 'what,' 'where,' 'when,' 'how,' and 'why' should be pursued. To avoid irrelevant material or omission of important facts, an investigator may assist a witness in preparing a written statement. When an investigator takes an oral statement, it should be reduced to writing and signed by the witness or certified by the investigator to be an accurate summary or verbatim transcript. Care should be taken to ensure that any statement is phrased in the actual language of the witness.

The IO stated he filled out the command interview forms, not the individuals themselves. The IO was unaware of JAGMAN requirements regarding witness interviews and did not know whether he could identify those he interviewed, so he did not attribute the information to anyone. The IO stated he assumed the command interview forms provided a sufficient means to document his interviews. When presented with the JAGMAN requirements, the IO admitted he didn't know better at the time but now, in retrospect, he would have obtained and documented better statements. Additionally, he did not document in his LOD information provided by witnesses as findings of fact.

[7] http://www.npc.navy.mil/CommandSupport/SuicidePrevention/HowtoHelp/warning_signs.htm

Opinions not supported by findings of fact. The IO reported HN Purcell had a "longstanding mental illness." His opinion was not supported by findings of fact. The IO coordinated with a medical doctor who reviewed HN Purcell's medical history. The medical doctor told the IO HN Purcell had a "longstanding mental illness." The JAGMAN requires opinions be "reasonable evaluations, inferences, or conclusions based on the facts found. Each opinion must cite the findings of fact upon which it was based." The IO failed to document the information the doctor provided as a finding of fact.

Additionally, the IO did not provide a history of medications prescribed for HN Purcell. A complete history of HN Purcell's prescription medication should have been documented; especially given the IO's finding in his LOD that HN Purcell had a history of mental illness before entering active duty. Coupled with the information the IO gathered during the course of his investigation, this information would have provided additional substantiating evidence of HN Purcell's mental illness history, which the IO opined was the contributing factor in his death.

Failure to make recommendations. The appointment letter directed the IO to make recommendations; however, his LOD investigation concluded with only findings of fact and opinions. The IO could not recall whether recommendations were required, but admitted there were several recommendations he could have made but he failed to do so. The IO stated, "I wish I would have done something different as far as the recommendation. What should I know today that my boss didn't know so we can prevent something like this potentially from happening again."

Insufficient command endorsements and review. The IO's LOD investigation contained endorsements of the CO, NHCNE and CO, Navy Medicine East. Neither endorser detected deficiencies in the LOD investigation or the IO's failure to provide recommendations. Both endorsements concurred with the IO's line of duty determination but failed to address whether he complied with the remaining directives assigned in his appointment orders.

We noted the Convening Authority (CA), in this instance CO, Naval Health Clinic New England, did not assign a reviewer. Per the JAGMAN, a reviewer can provide their own recommendations. Section 0238 of the JAGMAN states,

> To enhance the investigation process, prior to taking action on an investigative report which calls into question the propriety of a deceased individual's conduct, including all apparent suicide cases, the Convening Authority (CA) may cause the report to be reviewed by an individual not previously connected with the investigation process and outside the CA's immediate chain-of command.

The JAGMAN explains, if the CA selects a reviewer, the reviewer's responsibilities include "to critically analyze the salient circumstances surrounding the death as documented in the report so if the reviewer believes comments on the thoroughness of the investigation or the accuracy of its findings is warranted, then such comments shall be provided in writing to the CA." The CA should have assigned a reviewer for the IO's LOD investigation based on the following rationale:

- The contentious events of HN Purcell's suicide while in the custody of NASB Law enforcement.

- Historically, within DoD, suicide (as a manner of death) raises questions on what measures were in place to prevent the death.
- The IO's appointment orders directed an investigation not only into a line of duty determination but also into the events leading to HN Purcell's apprehension.
- The JAGMAN documents that commanders take "Special Considerations" for death investigations and specifically suicides, inferring the need for DoN officials to investigate such incidents to the fullest extent possible.

A reviewer could have identified the significant deficiencies in the IO's LOD investigation and provoked a re-investigation. Further, a re-investigation could have resulted in recommendations.

c. Did the Commanding Officer, NASB investigate the incident in accordance with DoD and DoN guidance?

We determined the CO, NASB properly appointed the IO to investigate the security response. The IO adequately investigated the complete security response to include policies, procedures, and training requirements. Although the command investigation was adequate, we identified two administrative deficiencies which did not impact the investigation's conclusions. Although we did not address them in our report, we detailed them in a memorandum to the CO, NASB recommending he reinforce compliance with JAGMAN procedural guidance.

Standards

The standard dictating the completion of command-directed investigations is JAG Instruction 5800.7D, "Manual of the Judge Advocate General," (JAGMAN), dated June 20, 2007. (See Appendix A).

Facts

On January 30, 2008, the CO, NASB, appointed an IO, to conduct a command investigation "into the facts and circumstances surrounding the NASB Brunswick Security response at the NASB Bachelor Housing on the evening of 27 January 2008," instructing the IO to "[I]nvestigate the complete security response in the light of the existing pertinent policies, procedures, and training requirements at the time of this incident."

In conducting the investigation, the IO interviewed the responding police officers and HN Purcell's co-workers, to include those who responded to the scene. Sworn written statements documented the interviews. The IO obtained the training records for those police officers and determined they received the necessary training to resolve the incident. Additionally, the IO reviewed local, regional, and DoN policy; his investigation included the citation for each policy pertaining to his findings of fact.

The final report contained 405 findings of fact. Per the JAGMAN, each finding must be supported by fact, recorded separately with the enclosure listed supporting that finding. He did that. Based on his findings, the IO outlined 53 opinions. The IO recommended 16 actions based

on his investigation. These actions ranged from disciplinary action against the responding police officers and their immediate supervisors to using this incident as an example within DoN to prevent reoccurrence. While the specific disciplinary actions the IO recommended did not occur, each of the responding officers and their immediate supervisors did receive disciplinary action. We address these actions later.

Through recommendations from his higher headquarters, MIDLANT, the CO, NASB endorsed the selection of the IO, in part, because of the IO's extensive legal experience. MIDLANT officials told us because of the potential impact the incident would have on security procedures on DoN installations, the IO selected was best qualified.

The Region Legal Servicing Officer (RLSO), MIDLANT, stated he and two other MIDLANT officers collaborated to identify a disinterested and experienced IO with knowledge in the "security area," and a "good knowledge of what the rules were so he could make an opinion as to whether or not the rules were actually followed." Someone suggested the IO.

The IO completed his investigation in the 30 days allotted. The IO stated he neither received guidance from the CO, NASB, regarding his investigation nor was he influenced regarding any of his findings or decisions by upper echelons at MIDLANT and DoN levels. The IO provided the completed report to the CO, NASB and the MIDLANT RLSO.

Although not required and while the IO did not obtain a legal review of his completed investigation, the MIDLANT RLSO reviewed it. She told us it was consistent with JAGMAN Chapter II, it "answered the assignment," and provided recommendations as directed. The RLSO also stated, "it was very well done."

The IO conducted interviews and collected documents in accordance with the JAGMAN. He interviewed the responding police officers, HN Purcell's co-workers and obtained the training records of the responding officers. The IO obtained written sworn statements from them, all of which contained specific details of the incident, as recommended by the JAGMAN.

Our review of the statements showed they were thorough as the IO asked probing questions as to who, what, where, when, how, and why, IAW JAGMAN instructions. The IO certified the training records as an accurate and true depiction of their originals, as required in the JAGMAN regarding collection of documentary evidence. We noted the IO collected the most up-to-date training information of the responding officers. We found this was a satisfactory method in order for the IO to opine on the adequacy of the NASB Security Department training program. After completing his interviews and collecting the necessary documents, the IO concluded, "[T]hrough neglect and culpable inefficiency by NAS Brunswick security personnel, HN Purcell was able to affect his suicide with a firearm while in their custody."

Discussion

We determined the CO, NASB, responded to the incident in accordance with DoD and DoN policies. Despite no requirement set forth I n the JAGMAN, the CO, NASB directed a command investigation. He reasoned deficiencies occurred on January 27, 2008, which required further examination. According to the JAGMAN, there are three types of administrative investigations – command, litigation, and courts and boards of inquiry. The JAGMAN provides several examples of reasons command administrative investigations are initiated. We noted none of the examples cited, mirrored or were similar to this incident. Furthermore, while the instruction indicated the CO is the decision authority for initiation of command investigations, the JAGMAN did not provide a requirement for the CO to initiate a command investigation into this incident. As it pertained to this incident, the only requirement set forth was a "line of duty death investigation," which we learned the Navy Bureau of Medicine and Surgery conducted.

Our review of the IO's investigation determined the findings of fact were as specific as possible as to times, places, persons, and events. He also documented each fact as a separate finding, and cited the enclosure supporting each finding, in accordance with JAGMAN instructions. Using his findings of fact, the IO documented opinions which we found were "reasonable evaluations, inferences, or conclusions based on the facts found." His opinions cited the findings of fact upon which they were based. We determined the IO's recommendations were "dependent on the nature of the facts found and opinions expressed." Our review of the IO's investigation determined he adequately developed his findings of facts, opinions, and recommendations. We found the IO's actions realistic and meeting the needs of the CO, NASB as addressed in the appointment orders.

2. Did DoN officials determine whether law enforcement training or qualifications were factors which contributed to HN Purcell's death while in custody?

DoN officials evaluated whether law enforcement training or qualifications contributed to Purcell's death. The IO's CDI investigation and our review determined the NASB training program provided the necessary training to the responding police officers and inadequate training did not contribute to HN Purcell's death.

Standards

There are four standards which dictate the training and qualifications for Navy law enforcement personnel. The standards include: DoDI 5210.90, "Minimum Training, Certification, and Physical Fitness Standards for Civilian Police and Security Guards (CP/SGs) in the Department of Defense," dated July 9, 2007; OPNAVINST 5530.14D, "Navy Physical Security and Law Enforcement Manual," dated January 30, 2007; OPNAV 5580.1A Navy Law Enforcement Manual, July 26, 2000; and Naval Air Station Brunswick (NASB) Standard Operating Procedures. (See Appendix A).

Facts

In accordance with his appointment orders, the IO examined training at the time of this incident.

The IO reviewed the training folders of each responding officer. During his CDI, the IO specifically examined training the responding officers received in the following areas:

- Phase I Training
- Phase II Training
- Search and Seizure
- Apprehension versus Arrest
- Suicide Prevention/Crisis Intervention
- Pedestrian Searches
- Apprehension, Restraint and Release of Suspects/Detention of Apprehended Personnel/Transporting Prisoners/Prisoner Handling
- Use of Deadly Force
- Interview and Interrogation Techniques

The IO interviewed the responding officers and obtained sworn testimony from them about their training and level of experience. Once the IO gathered the appropriate documents and reviewed the officers' testimonies, he concluded, "[A]ll NAS Brunswick Security personnel involved in this incident had received the proper training needed to adequately diffuse and resolve this incident safely." The IO also concluded, "[A]ll NAS Brunswick Security Personnel were properly qualified for their respective post assignments."

We also reviewed the training jackets of the NASB police officers. Every police officer possessed a training jacket as required. We found the training jackets well-maintained and easy to assess. Each jacket contained a chronological tabulated sheet containing the type of training provided, when the training was provided, who provided the training and an acknowledgement by the police officer they had received the training.

Our review of MIDLANT's inspections of NASB showed NASB complied with DoN standards regarding frequency and conduct of training. We also reviewed monthly NASB internal inspections conducted by the various Field Training Officers (FTOs). We found the inspections detailed, specifically identifying the topic trained on, date of the training, who provided the training, and who attended the training. We noted training was current and complied with DoD and DoN guidance and training was given by qualified instructors. On interview, the NASB Security Director told us,

> When I came here [January 2000] there was none [training program]. I started to build a department and get away from primarily all physical security guards and into the police world. They're more functional. We have followed the SECNAV and OPNAV training requirements ever since. I have in -- after 9/11 we sent two MAs to become master trainers, the Navy school, and I've had master trainers ever since then.

We confirmed the NASB police officers completed Phase I training requirements; they attended local schooling, regional police academies, or MA School as required. We determined the areas the IO identified above dealt specifically with the deficiencies he noted as occurring the night of January 27, 2008. According to policy, police officers/MAs receive training on these tasks during Phase I, Phase II, during in-service training, or a combination thereof. Once a police officer/MA completes their respective Phase I training, they are eligible to perform law enforcement duties.

DoN policy requires police officers/MA's maintain proficiency in many of the law enforcement training tasks they received during Phase I training. They accomplish this by mandating police officers/MAs receive sustainment or Phase II training. According to DoN and subordinate command policies, police officers/MAs receive Phase II training annually.

According to NASB SOP, Phase II training encompasses, "the minimum maintenance of training standards essential to enable security force personnel to perform their duties; and Phase II training will be conducted annually for all security force personnel. Phase II training is mandatory and personnel will not be authorized to perform law enforcement duties without its satisfactory completion."

While DoN policy requires Phase II training tasks during a 1-year period, each task requires police officers/MAs to receive that training either annually, semi-annually, quarterly, monthly, during daily guard mount, or on an as needed basis.

The IO reviewed the responding officers' training records and determined they completed the required training in accordance with DoN policy. Our review confirmed the IO's findings.

The IO also interviewed the responding officers who stated they received training specific to the HN Purcell incident. All of the responding officers told us training was conducted and annotated in their training files. Additionally, when we asked the officers to verbally articulate some of the aforementioned training areas the IO identified, they adequately provided step by step descriptions of actions necessary to complete the task.

Discussion

We determined that DoN officials evaluated the NASB Security Department training program and determined law enforcement training and qualifications were not factors contributing to HN Purcell's death. We interviewed the IO, the responding police officers, and the supervisors responsible for the overall NASB law enforcement training program. We also interviewed MIDLANT officials. We reviewed the IO's CDI investigation and NASB police officer training jackets. We gathered the applicable DoD and DoN policy guidance and analyzed it against the documents we collected.

We determined the NASB Security Directorate complied with DoD and DoN regulatory requirements in providing the mandatory police officer training to their respective police officers. We found the police officer training jackets reflected the training received, and the NASB FTO program adhered to policy regarding the conduct and frequency of training.

We examined the IO's efforts and found his methodology of reviewing the police officer training records and conducting interviews was sound. We agreed with the IO's command investigation findings; the responding police officers were trained and qualified to perform their duties.

3. Did DoN officials implement adequate corrective measures to prevent future occurrences?

DoN officials implemented corrective measures to prevent recurrences similar to HN Purcell's death. The CO, NASB initiated a command administrative investigation despite no regulatory requirement to do so, and he ensured the IO's recommendations were implemented. The IO's recommendations were based on DoD and DoN standards, and detailed corrective measures to prevent similar incidents.

Standards

There are three standards applicable to this question including: OPNAVINST 5530.14D, "Navy Physical Security and Law Enforcement Manual," dated January 30, 2007; Commander Navy Region Mid-Atlantic (COMNAVREG MIDLANT) 5500.2, "Regional Physical Security Standard Operating Procedures," undated; and NASB Standard Operating Procedures (SOP), 2005. (See Appendix A).

Facts

On January 27, 2008, HN Purcell committed suicide using a weapon he purchased in November 2007. HN Purcell was placed in hand restraints by NASB law enforcement; however, a law enforcement officer later released him from those restraints which enabled him to commit suicide while in police custody.

The IO was required to look at policies and procedures in place when the incident occurred and to investigate the "complete security response" in light of those policies and procedures.

The CO, NASB immediately removed the responding officers from their law enforcement duties and placed them on administrative duty pending completion of the investigation.

On February 29, 2008, the IO completed his CDI investigation, making 16 recommendations. On March 20, 2008, the CO, NASB, endorsed the IO's CDI investigation, concurring with his recommendations. The CO, NASB lacked the authority to take disciplinary action against the DoN civilian police officers. Therefore, he did not endorse those recommendations, but deferred to the Director of Public Safety who did. During the process of completing the IO's recommendations, the CO, NASB transferred under a routine reassignment action. The incoming CO, NASB endorsed the IO's findings and continued to implement the recommendations. We compiled those recommendations into four distinct areas:

- Recommendation to take disciplinary action against the responding police officers and their supervisors.
- Recommendation that NASB conduct a safety stand-down to review all regulatory guidance and SOP's relevant to apprehension, search, restraint, transport of suspects and Suicide Awareness.
- Recommendation that current and future police officers attend the 14-week police academy.
- Recommendation that higher headquarters conduct a training audit of the NASB Security Office's training program.

Disciplinary action against responding police officers and supervisors. The CO, NASB initiated court-martial proceedings against the two active duty (sailors) MAs. During the initial proceedings, one of the sailors accepted a pre-trial agreement; however, during his Article 39a, Uniform Code of Military Justice "providency" hearing, the sailor could not explain to the presiding judge how he was derelict in his duties or how he had committed a crime. After hearing the sailor's testimony, the judge informed the court he saw no crime in the sailor's actions. The NASB Staff Judge Advocate (SJA) told us they appeared before the, ". . . Chief Judge of our military judiciary" and the judge said ". . . that's great but I don't see any criminality to what occurred here. . . ." Following the Article 39a appearance, the CO, NASB administered non-judicial punishment (NJP) to both sailors. On interview, the CO, NASB told us,

> . . . I think that was the turning point where I started to go, 'All right, so here I've got a judge supposedly an expert in his field who says there was no criminal neglect in what happened; it was tragic. There was dereliction but there wasn't any criminal neglect and didn't think it ought to be in the court martial realm.' And if it stayed in the court martial realm he probably would find him innocent. And that outcome would not be acceptable to me.

The NASB RLSO explained a portion of the NJP, stating " . . . they had a retraining period. Both sailors lost all of their administrative qualifications. They both started from ground zero over again." Both sailors were also required to complete reviews of the NASB training program and the MA training school at Lackland AFB. The NASB RLSO stated the sailors developed local training scenarios specific to volatile incidents, such as the one they experienced with HN Purcell.

On interview the NASB Security Director confirmed the NASB SJA's comments, stating,

> He [one of the active duty sailors] was relieved of his duties as watch commander right after the incident occurred as was the second sailor, and after their captain's mast,[8] they were both put back on the bottom of the pile and they had to completely redo the whole program. The Captain was insistent and I agreed that they not just gun deck it, you know, don't just mark them off because they know all the answers. They were forced to do each and everything in the JQR [Job Qualification Requirements] one by one and be grilled and tested by my board. It took them quite a while to get through the JQRs.

[8] Captain's mast is a colloquial Navy term for the administering of NJP to sailors or U.S. Marine Corps personnel.

We reviewed the NASB Security Department's SOP and noted changes were made to the standards in the newest version of the SOP dated August 2008. We noted these changes updated the training to include more hands-on training. The NASB Security Director stated,

> They [the two sailors] did, they absolutely did that. We've incorporated it into their phase II training. They did a really good job. They recommended some changes to the SOP's, and we've made those.

Of the six responding DoN civilian police officers, three received suspensions without pay, ranging from 2 to 14 days. Two officers resigned and/or retired before disciplinary action was taken. The police officer who departed the scene before HN Purcell was placed in restraints and prior to his death received no punishment. The NASB Security Director and his deputy received suspensions without pay, 14 days and 10 days respectively. We noted the recommendations to take disciplinary action against the police officers and supervisors were timely.

Safety stand-down to review relevant regulatory guidance and SOPs. The CO, NASB immediately directed the NASB Security Director to conduct a safety stand-down. The CO, NASB stated, " . . . immediately, as soon as possible, sit down the precinct and review whatever procedures were messed up that resulted in this. And to reemphasize correct procedures and sticking to it."

The NASB Security Director told us they conducted the safety stand-down in February 2008, for the 47 assigned personnel. He said the stand-down covered: Apprehension/Detention of Suspects; Restraint/Searching/Release of Suspects, and Transporting Suspects. Additionally, they conducted several drill scenarios on the handling of suicide calls. The Chaplain's Office, NCIS, CID, and the Fleet and Family Support Center provided training on the handling of similar situations. We reviewed the training records the IO collected during the course of his CDI and confirmed the training was conducted. Between August 18 - 22, 2008, MIDLANT Public Safety Training Academy instructors provided additional classroom instruction to NASB Security personnel concerning Handling High Risk Situations and Apprehension, Handcuffing, Searching, and Transporting. The instructors also conducted practical application and scenario based training concerning handcuffing and searching.

Current and future police officers attend the 14-week police academy. The recommendation was implemented in part. Since the incident, NASB hired two DoN police officers, both attended the academy. The DoN police currently employed at NASB were grandfathered and not required to attend the academy. This decision was based on the current DoN police officers having previously attended Phase I and Phase II training. This decision complied with OPNAVINST 5530.14D, "Navy Physical Security and Law Enforcement Manual," dated January 30, 2007.

Training inspection of the NASB Security Office's training program. Since January 2008, the NASB Security Directorate training program has been inspected three times. We considered the first inspection as conducted by the IO during the course of his investigation. The IO found the NASB training program was adequate and the necessary tools were available and presented during instruction to have successfully resolved the HN Purcell incident. We concurred. In June

2008, MIDLANT conducted a second training inspection with a third inspection completed in September 2009. While the MIDLANT training policy does not have a "passing" standard, it does require annual audits.

In addition to the MIDLANT training audit, the NASB Security Director also conducts quarterly audits and each Watch Commander conducts their own monthly internal self-audit. According to the Deputy Security Director, he requires watch commanders and captains to do monthly audits of the other platoons. He also requires feedback to the watch commander and FTO on existing shortcomings.

We also noted MIDLANT began a training scenario called "Verbal Judo." Verbal Judo is a tactical communication training course. It teaches use of presence and words to calm difficult people, who may be under severe emotional or other influences, redirect the behavior of hostile people, diffuse potentially dangerous situations, perform professionally under all conditions and achieve the desired outcome. MIDLANT implemented the training for all subordinate security departments and provided the training to NASB in September 2009.

Discussion

Our review determined DoN officials initiated a command administrative investigation despite no regulatory requirement to do so and implemented the IO's recommendations. We found that the IO's recommendations were credible, based on DoD and DoN standards, and detailed corrective measures to prevent future recurrences.

We found the IO's CDI investigation thorough and detailed. We believe the IO identified the failures of the responding police officers. His recommendations addressed a wide spectrum of deficiencies requiring action by MIDLANT and NASB officials. We found MIDLANT and NASB officials endorsed the IO's recommendations and took corrective action. MIDLANT conducted training on search and seizure, handcuffing procedures and apprehension versus arrest.

On interview the responding police officers informed us training improved since the incident. Disciplinary action was initiated and/or taken against those involved in the incident to include the supervisors of the NASB Security department. Review of training curriculum was conducted and recommendations were made to change how training is presented to police officers/MAs. Our review of the changes implemented subsequent to the IO's CDI investigation should further reduce the risk of a similar incident re-occurring.

4. Did DoN officials properly disclose information in response to Mr. Purcell's Freedom of Information Act request?

We determined DoN officials disclosed information in response to Mr. Purcell's FOIA request and all disclosures made to Mr. Purcell complied with Privacy Act and FOIA standards.

Standards

There are six standards applicable to this objective. The standards include: United States Code (USC), Section 552, "The Freedom of Information Act," dated 1996; DoD Directive 5400.11, "DoD FOIA Program," dated May 14, 2007; DoD Directive 5400.07, "DoD Freedom of Information Act (FOIA) Program," January 2, 2008; DoD Directive 5400.7-R, "DoD Freedom of Information Act Program," dated September 4, 1998; Secretary of the Navy Instruction (SECNAVINST) 5211.5E, "Department of the Navy Privacy Program," dated December 28, 2005; and SECNAVINST 5720.42F, "Department of the Navy Freedom of Information Act (FOIA) Program," dated January 6, 1999. (See Appendix A).

Facts

In March 2008, Mr. Purcell submitted a FOIA request to release documents related to his son's death. Mr. Purcell requested the following:

1. NAS Brunswick CDO/Quarterdeck Log from 0001 (12:01 AM) on January 27, 2008 through 2359 (11:59 PM) on January 28, 2008;
2. Any SITREPS concerning Hospitalman Christopher L. Purcell;
3. NAS Brunswick Security/Base police Log or reports concerning Hospitalman Christopher L. Purcell;
4. Copies of NAS Brunswick Security/Base Police Standard Operating Procedures with regard to the first responders of suicide threats, gestures or to entering residences where the occupants are declared to be armed and despondent.

DoN officials released to Mr. Purcell items (1) through (3) above with the exception of personal information involving third-party persons. DoN officials cited their FOIA Program instruction, SECNAVINST 5720.42F, exemption (b)(6) which "denies disclosure of information in personnel and medical files, as well as similar personal information in other files, that, if disclosed to a FOIA requester, other than the person about whom the information is about, would result in a clearly unwarranted invasion of personal privacy." Further, DoN Privacy Program instruction, SECNAVINST 5211.5E defines personal information "as information about an individual that identifies, relates, or is unique to, or describes him or her (e.g., social security number, age, military rank, civilian grade, marital status, race, salary, home/office numbers, etc.) or that may be used to distinguish or trace an individual's identity." DoN officials did not provide material in item (4) citing the following explanation, "as the Standard Operating procedures is exempt from disclosure under the provisions of FOIA exemption (b)(2). This document meets the two requirements of this exemption because it is predominantly internal and its disclosure significantly risks circumvention of agency regulations and statute."

On April 30, 2008, Mr. Purcell submitted a FOIA request to release the command investigation conducted by the IO. DoN officials released the command investigation with the exception of names, personal identifiers, personal information, diplomas, and certificates as it involved personal information involving third-party individuals. DoN officials cited again SECNAVINST 5720.42F, exemption (b)(6) and SECNAVINST 5211.5E as explanation for the

non-disclosure of personal information. DoN officials did not release the opinions and recommendations of the IO, citing FOIA exemption (b)(5) which "denies disclosure of documents considered privileged in litigation, primarily under the deliberative process privilege." In order to meet the test of this exemption, the record must be both deliberative in nature, as well as part of a decision-making process. As examples of documents that would be part of a deliberative process, SECNAVINST 5720.42F identifies "official reports of inspection, reports of the Inspectors General, audits, investigations, or surveys pertaining to the safety, security, or the internal management, administration, or operation of one or more DoN activities, when these records have traditionally been treated by the courts as privileged against disclosure in litigation."

In August 2008, Mr. Purcell complained to the Defense Hotline that his son was in the "protective custody" of at least six "improperly trained" active duty Navy and DoD security officers. Mr. Purcell reported the two Petty Officers (Masters at Arms) alleged to be in charge of the scene, had been referred to a special court martial; however, it was deferred to "Captain's Mast."[9] Mr. Purcell complained the disposition of command action against the Masters at Arms and the DoD security officers were neither accessible to the public nor to the bereaved family.

On October 6, 2008, Mr. Purcell submitted a third FOIA request for the release of all transcripts, documents or reports pertaining to the sailors' courts-martial. DoN officials denied Mr. Purcell's request, citing SECNAVINST 5720.42F, exemption (b)(6) and SECNAVINST 5211.5E. DoN officials wrote to the Purcell's,

> the information Mr. Purcell seeks is not available to the public. The files contain reports, records, and other material pertaining to personnel matters in which administrative action, including disciplinary action, was taken. FOIA Exemption (b) (6) denies disclosure of information in personnel and medical files, as well as similar personal information in other files, that, if disclosed to a FOIA requester, other than the person about whom the information is about, would result in a clearly unwarranted invasion of personal privacy. All information that applies to a particular individual meets the threshold requirement for Exemption 6 protection. This means, of course, that this threshold is met if the information applies to any particular, identifiable individual. The privacy interest outweighs the public interest therefore, we withheld the requested information.

On November 21, 2008, Mr. Purcell appealed the decision through the Office of the Judge Advocate General (OTJAG), stating his belief that results of the "mast" could be released with identifying information redacted and that redacted *mast* results are routinely published Navy-wide. On December 30, 2008, OTJAG responded to Mr. Purcell and denied his appeal stating,

> While it is true that within commands these dispositions are reported, regulations provide that the announcement of non-judicial punishment dispositions is a proper exercise of command authority and not a release of information under FOIA. These announcements are not made available to the public. Based on these laws and regulations, and how the courts have interpreted them, OTJAG concluded that releasing additional information would constitute a clearly unwarranted invasion of the personal privacy of third persons.

[9] See footnote 7 for a definition of Captain's Mast.

OTJAG also confirmed that the maximum punishment at mast for both active duty sailors would have been 45 days of restriction, 45 days of extra duty, forfeiture of one-half month's pay for two months, a rank reduction of one grade, and an oral or written reprimand.

In February 2009, Mr. Purcell wrote to Representative Mark Steven Kirk (R – IL) and reiterated his concern DoN officials have not disclosed information to him regarding disciplinary action taken against the individuals involved in his son's death.

On July 20, 2009, Mr. Purcell submitted a FOIA request per President Obama's FOIA Memorandum for

> a less redacted version of the Naval Air Station Brunswick JAGMAN investigation report surrounding the events that enabled HN Christopher L Purcell to commit suicide on 27 Jan 08. Most specifically the nine pages of opinions and recommendations that were redacted.

DoN officials, in light of the President Obama's FOIA Memorandum and Attorney General Holder's FOIA Guidelines, Creating a "New Era of Open Government," re-processed the 9 pages of opinions and recommendations. However, DoN officials withheld names of third-parties, administrative action and disciplinary action pertaining to personnel, citing again DoN FOIA exemption (b)(6) and the DoN Privacy Program, SECNAVINST 5211.5E.

Discussion

We determined DoN officials properly disclosed information in response to Mr. Purcell's FOIA request and disclosures made to Mr. Purcell complied with Privacy Act and FOIA standards.

We collected and reviewed emails communicated between the Purcell family and DoN officials and documents provided to the Purcell family per their FOIA request. During our interview of the Purcell's, they told us they received what was requested except for reports of disciplinary action taken against the DoD civilian police officers and active duty MAs involved in the incident. The Purcell's stated they asked the MIDLANT RLSO " . . . a couple of months ago if he could give me their [the sailors'] current ranks, their rate. . . , he said due to their privacy, for privacy reasons, he can't tell me what the ranks are."

Throughout the FOIA process for the five Purcell FOIA requests, DoN officials cited the applicable policy governing release of information and provided the Purcell family with the appeal process if they disagreed with the DoN's decision. As indicated, the Purcell family did appeal the DoN decision not to release the NJP of the two active duty sailors through OTJAG. OTJAG further informed the Purcell's that while their appeal was final, they could seek judicial review of OTJAG's decision. As of the date of this report, the Purcell's have not sought a further review although they have continued their requests through several DoN channels, to include the Secretary of the Navy.

The Purcell family initially received a redacted copy of the IO's investigation which did not include his opinions and recommendations. After their appeal was denied by OTJAG, the Purcell submitted a follow-on FOIA request at which time the Purcell family was provided a

second revised redaction of the IO's investigation with his opinions and recommendations. DoN officials provided the Purcell family the applicable FOIA exemptions for the portion of documents not disclosed which was specifically the NJP of the two sailors. DoN officials maintained the release of this information would be an unnecessary invasion of privacy and further that such information was not a matter of public record.

During our review of FOIA and DoN Privacy Program, we noted the provisions should be read together. FOIA Exemption (b)(6) prohibits release of Privacy Act protected information in a NJP file (a record pertaining to a personnel matter in which administrative action, including disciplinary action, may be taken) to a third party (someone not the subject of the NJP). Paragraph C4.2.2.5.2 of DoD 5400-11-R, "DoD Privacy Act Program," dated May 8, 2007, allows release of rank (in this case from somewhere other than the NJP). Either request -- for the NJP record or rank -- from a third party would be examined first, under 5400.11-R (to determine if the information is protected by the Privacy Act), then under FOIA IAW DoD 5400.11-R, "DoD Freedom of Information Act Program," dated September 4, 1998. The existence of NJP, the NJP itself, and information from it would not be released per C3.2.1.6.1.2. However, rank alone could be released under 5400.7-R, paragraph C4.2.2.5.2 from some source other than the NJP. In our interviews, MIDLANT legal services officers , both FOIA attorneys involved in the Purcell FOIA requests, told us while rank may be released, in this particular instance with the two sailors to release their current rank would provide the Purcell family direct knowledge of NJP, which is not releasable. The MIDLANT RLSO explained,

> Once he [CO, NASB] signs an actual charge sheet that sort of like a Grand Jury Indictment, it then becomes part of public record. So the minute that charges are actually referred against a sailor then that information can become releasable, okay? If a commanding officer takes non-judicial action, so outside of the courtroom, that is based purely on administrative grounds such as a non judicial punishment…those things are considered to be non judicial in nature or administrative and those things are not releasable.

We coordinated with the DoD IG Office of General Counsel (OGC) and FOIA Release Specialist regarding the FOIA and Privacy Act provisions. While the release of military rank could be allowed, the final decision authority rested with DoN officials. As such, DoN officials were authorized to withhold any form of personal information which coincided with the NJP of the two sailors.

V. CONCLUSIONS

NCIS concluded the cause of HN Purcell's death was a gunshot wound to the chest and the manner of his death was suicide. The NCIS investigation was adequate.

Although the LOD IO determined HN Purcell's death was in the line of duty, his investigation was not conducted in accordance with JAGMAN instructions. The IO did not recognize information he collected regarding HN Purcell's behavior was consistent with suicidal behavior warning signs. We found he erred in his report when he opined "[T]here was no concrete warning or indication that he would take his own life up until his call . . . the evening of 27 Jan 08." The IO also failed to investigate command actions taken in response to those warnings. The behavior included several instances where co-workers informed HN Purcell's supervisor about the sale of his personal possessions, depressed mood and excessive drinking.

The IO's LOD investigation showed changes in HN Purcell's behavior were observed as early as 3 months before HN Purcell's death. Additionally, the IO did not conduct thorough interviews to obtain details of events leading up to HN Purcell's death, and he did not properly document information he obtained during interviews. Further, the CO, NHCNE and the CO, Navy Medicine East did not comply with the JAGMAN instructions when they endorsed the inadequate line of duty investigation report.

The CDI IO investigated the complete security response including pertinent policies, procedures, and training requirements as ordered and in compliance with the JAGMAN instructions.

DoN officials evaluated whether law enforcement training or qualifications were factors which contributed to Purcell's death while in custody. The CDI and our review determined the NASB training program complied with applicable training standards and NASB provided the required training to the responding police officers. We determined inadequate training was not a contributing factor leading to HN Purcell's death.

DoN officials implemented corrective measures to prevent recurrences similar to HN Purcell's death. The CO, NASB initiated a command administrative investigation despite no regulatory requirement to do so, and he ensured the IO's recommendations were implemented. The IO's recommendations were based on DoD and DoN standards.

DoN officials disclosed information in response to Mr. Purcell's FOIA request and all disclosures made to Mr. Purcell conformed to Privacy Act and FOIA standards.

VI. RECOMMENDATION

We recommend Department of Navy Bureau of Medicine correct the deficiencies in the line of duty investigation, including thoroughly documenting and supporting findings of facts, investigating the command's response to suicide warning signs displayed by Hospitalman Purcell and apparently recognized by others, and making recommendations as originally directed by the convening authority.

VII. MANAGEMENT COMMENTS AND OUR EVALUATION

In response to the draft report, we received management comments from the Assistant Secretary of the Navy, Manpower & Reserve Affairs. The Navy concurred with our recommendation and told us the Bureau of Medicine and Surgery has directed Navy Medicine East to reopen and complete the investigation in a manner consistent with the draft report.

The full-text management comments are included as Appendix C.

APPENDICES

Appendix A through Appendix D to the report follow.

Appendix A. Standards Related to the DoN response to HN Purcell's death

5 United States Code (USC), Section 552, "The Freedom of Information Act," dated 1996

This statute deals with the nine exemptions to FOIA which address issues of sensitivity and personal rights. Three of these exemptions are identified in the body of our report as explanations for non-disclosure of information:

(b)(2) "*Related solely to the internal personnel rules and practices of an agency*." This exemption is entirely discretionary and pertains to records containing or constituting statutes, rules, regulations, orders, manuals, directives, instructions, and security classification guides, the release of which would allow circumvention of these records thereby substantially hindering the effective performance of a significant function of the DON. For example: (a) those operating rules, guidelines, and manuals for DON investigators, inspectors, auditors, or examiners that must remain privileged in order for the DON activity fulfill a legal requirement; (b) personnel and other administrative matters, such as examination questions and answers used in training courses or in the determination of the qualifications of candidates for employment, entrance on duty, advancement, or promotion; (c) computer software, the release of which would allow circumvention of a statute or DON rules, regulations, orders, manuals, directives, or instructions. In this situation, the use of the software must be closely examined to ensure a circumvention possibility exists.

(b)(5) "Inter-agency or intra-agency memoranda or letters which would not be available by law to a party other than an agency in litigation with the agency." For example: internal advice, recommendations, and subjective evaluations, as contrasted with factual matters that are reflected in deliberative records pertaining to the decision-making process of an agency, whether within or among agencies or within or among DON activities. In order to meet the test of this exemption, the record must be both deliberative in nature, as well as part of a decision-making process. Merely being an internal record is insufficient basis for withholding under this exemption. Also potentially exempted are records pertaining to the attorney-client privilege and the attorney work-product privilege. This exemption is entirely discretionary. The example as used in this report is those portions of official reports of inspection, reports of the Inspector Generals, audits, investigations, or surveys pertaining to safety, security, or the internal management, administration, or operation of one or more DON activities, when these records have traditionally been treated by the courts as privileged against disclosure in litigation.

(b)(6) "*Personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy*." Release of information about an individual contained in a Privacy Act System of records that would constitute a clearly unwarranted invasion of privacy is prohibited, and could subject the releaser to civil and criminal penalties. If the information qualifies as exemption (b) (6) information, there is no discretion in its release. An example of other files containing personal information similar to that contained in personnel and medical files include, as noted in our report: Files containing reports, records, and other material pertaining to personnel matters in which administrative action, including disciplinary action, may be taken.

Department of Defense (DoD) Directive 5400.11, "DoD FOIA Program," dated May 14, 2007.

This directive provides guidance on section 552 of Title 5 United States Code (U.S.C.), the Privacy Act of 1974 and prescribes uniform procedures for implementation of the DoD Privacy Program. As it pertains to our review, we noted paragraph C4.2.2.5.2 "Military Members," which states,

> While it is not possible to identify categorically information that must be released or withheld from military personnel records in every instance, the following items of personal information regarding individual military members normally may be disclosed without a clearly unwarranted invasion of their personal privacy: full name, rank, etc.

DoD Directive 5400.07, "DoD Freedom of Information Act (FOIA) Program," January 2, 2008.

This directive updates policies and responsibilities for implementing the DoD FOIA Program in accordance with Reference (1) (commonly known as the "FOIA") and continues to authorize Reference (4) below to implement the FOIA Program.

DoD Directive 5400.7-R, "DoD Freedom of Information Act Program," dated September 4, 1998.

This directive provides guidance on the implementation of the FOIA. As it pertains to our report, the directive identifies the nine exemptions. Under paragraph C3.2.1.6, exemption Number 6. (5 U.S.C. 552 (b)(6)) (Reference (1) above) states,

> "Information in personnel and medical files, as well as similar personal information in other files, that, if disclosed to a requester, other than the person about whom the information is about, would result in a clearly unwarranted invasion of personal privacy. Release of information about an individual contained in a Privacy Act System of records that would constitute a clearly unwarranted invasion of privacy is prohibited, and could subject the releaser to civil and criminal penalties. If the information qualifies as Exemption 6 information, there is no discretion in its release."

Examples of other files containing personal information similar to that contained in personnel and medical files include under subheading C3.2.1.6.1.2, "Files containing reports, records, and other material pertaining to personnel matters in which administrative action, including disciplinary action, may be taken."

Department of Defense Instruction (DoDI) 5505.10, "Investigation of Noncombat Deaths of Active Duty Members of the Armed Forces," dated January 31, 1996

This instruction implements policy for the investigation of noncombat deaths of members of the Armed Forces not medically determined to be from natural causes. Under paragraph 4.1, the instruction requires "All noncombat deaths of members of the Armed Forces on active duty, not medically determined to be from natural causes, shall be investigated as potential homicides until evidence establishes otherwise."

DoDI 5210.90, "Minimum Training, Certification, and Physical Fitness Standards for Civilian Police and Security Guards (CP/SGs) in the Department of Defense," dated July 9, 2007

This policy provides for the minimum training, certification and physical fitness standards for civilian police and security guards. Under paragraph 3.1, "DoD CP/SGs are provided standardized law enforcement and security training that meets the DoD minimum standards in order to satisfactorily perform their full range of essential duties." Paragraph 3.2 states,

> There must be a certification program for CP/SGs requiring initial and sustainment training, approved physical fitness standards and, at minimum, qualification with assigned weapons. The established DoD law enforcement and security training standards (published by the DoD Executive Agent, reference section 4.2.2.) serve as minimum training standards for all DoD Civilian Police (Series 0083 or equivalent) and Security Guards (Series 0085 or equivalent).

Secretary of the Navy Instruction (SECNAVINST) 5211.5E, "Department of the Navy Privacy Program," dated December 28, 2005.

The purpose of this instruction is to implement references (1) and (2) above to ensure that all DON military members and civilian/contractor employees are made fully aware of their rights and responsibilities under the provisions of the Privacy Act (PA); to balance the government's need to maintain information with the obligation to protect individuals against unwarranted invasions of their privacy stemming from the DON's collection, maintenance, use, and disclosure of Protected Personal Information (PPI); and to require privacy management practices and procedures be employed to evaluate privacy risks in publicly accessible DON web sites and unclassified non-national security information systems. The Instruction further provides guidance on how to respond to individuals who seek access to information in a PA system of records that is retrieved by their name and/or personal identifier. For the purpose of our review, this Instruction defines personal information as "Information about an individual that identifies, relates, or is unique to, or describes him or her (e.g., SSN, age, military rank, civilian grade, marital status, race, salary, home/office phone numbers, etc.)."

SECNAVINST 5720.42F, "Department of the Navy Freedom of Information Act (FOIA) Program," dated January 6, 1999

This Instruction issues Department of the Navy (DON) policies and procedures for implementing references (1) and (2) above and promotes uniformity in the DON Freedom of Information Act (FOIA) Program. The Instruction outlines the nine exemptions in Reference (1) and its applicability to the DoN. Those exemptions within this Instruction are mirrored above and will therefore not be repeated.

SECNAVINST 5430.107, "Mission and Functions of the Naval Criminal Investigative Service," dated December 28, 2005

This instruction mandates under paragraph 7b(1)a

> Any non-combat death, on or off naval installations, facilities, vessels, or aircraft, where the cause of death cannot be medically attributable to disease or natural causes. Pursuant to reference (p), NCIS shall investigate the circumstances until criminal causality can be reasonably excluded.

JAG Instruction 5800.7D, "Manual of the Judge Advocate General," dated June 20, 2007.

This instruction provides the DoN guidance on matters pertaining to the Judge Advocate General Corps. Chapter II, Administrative Investigations, sets forth principles governing the convening, conduct, review, and storage of administrative investigations conducted in or by the Department of the Navy (DON) under the authority of this Manual.

Section 0201 (SCOPE)

Paragraph d. Coordination with law enforcement investigations. Before conducting a preliminary inquiry or convening an investigation under this chapter, a commander shall ascertain, through liaison with the Naval Criminal Investigation Service (NCIS), whether a law enforcement investigation (military, federal, or civil) is pending in the same matter. If a law enforcement investigation is pending, the commander should determine whether the law enforcement investigation will serve to appropriately document the matter without further investigation under this chapter, see section 0216h(2) and Part G. If the commander determines that a preliminary inquiry or investigation needs to be conducted in addition to the law enforcement investigation he shall:

(1) Coordinate any preliminary inquiry or investigation with the cognizant law enforcement agency through NCIS, unless NCIS declines, in which case direct liaison may be made. It is recommended that the commander include written direction that the officials being tasked to conduct the preliminary inquiry or investigation communicate and coordinate their efforts with the cognizant law enforcement agency.

(2) Refer to the Region Commander, his designee, or, in the case of the Marine Corps, to the general court-martial convening authority (GCMCA), via the chain-of-command, any conflicts between the law enforcement agency and the commander that cannot be resolved locally, and suspend action on the contested matter pending resolution. For example, if NCIS, on behalf of itself or another law enforcement agency, objects to the convening of an investigation under this chapter, the commander will not convene the investigation until the matter is resolved by the designated higher authority. Similarly, if an investigation under this chapter is in progress but NCIS objects to the interview of a specific witness, the witness will not be interviewed until the matter is resolved by the higher designated authority; although, in this example, other aspects of the investigation could continue to be worked.

0208 TYPE ONE: COMMAND INVSTIGATIONS

a. Purpose. A command investigation functions to gather, analyze, and record relevant information about an incident or event of primary interest to command authorities. Most investigations will be of this nature. Command investigations may, for example, be used to inquire into:

(1) significant property losses (minor property losses in most cases will be adequately documented through other means), other than damage to or destruction of public quarters since such incidents are likely to result in claims against or for the Government and, consequently, require a litigation report investigation;

(2) incidents in which a member of the naval service, as a result of possible misconduct, incurs a disease or injury that may result in a permanent disability or a physical inability to perform duty for a period exceeding 24 hours (distinguished from a period of hospitalization for evaluation or observation); see Part E;

(3) deaths of military personnel, or of civilian personnel occurring aboard an activity under military control, apparently caused by suicide or under other unusual circumstances; see part F for special considerations in death cases; and

(4) aircraft incidents, groundings, floodings, fires, and collisions not determined to be major incidents; see part G for guidance on investigating specific types of incident.

b. Convening order. The convening order:

(1) should direct the investigating officer to seek the assistance of a judge advocate;

(2) may direct the investigating officer to provide opinions or recommendations in addition to finding facts;

(3) shall specify when the investigative report is due;

(4) may not designate parties;

(5) shall direct, in applicable cases, per section 0202, investigators to coordinate the command investigation with NCIS/Security personnel who may be conducting criminal investigations, requiring the report of any conflict to the CA for resolution; and

(6) should identify potential witnesses and sources of information, and otherwise provide such direction as the CA determines necessary or proper, including specifying the format in which the report will be submitted. Normally, a letter report supported by enclosures will be specified. See Appendix A-2-c for a sample convening order and report.

c. Method

(1) A command investigation --

(a) is convened in writing;

(b) is conducted by one or more persons in the DON;

(c) collects evidence by personal interviews, telephone inquiries, or written correspondence;

(d) is documented in writing in the manner prescribed by the CA in the convening order;

(e) does not involve hearings; and

(f) may contain sworn statements signed by witnesses.

(2) A command investigation may assign certain issues, witnesses, or specific matters to individual members for investigation if more than one investigating officer is appointed, and hold later meetings to review the information collected for completeness. Additionally, the investigation may proceed by calling witnesses to present testimony or by obtaining information through personal interview, correspondence, telephone inquiry, or other means.

f. Time limitations. The CA will prescribe when the report is due, normally 30 days from the date of the convening order, except in death cases, however, where the investigation is to be completed 20 days from the date of the death, or its discovery. The CA may grant extensions as necessary. Requests and authorizations for extensions need not be in writing but must be memorialized in the preliminary statement and/or endorsement, as applicable.

0211 CONVENING ORDERS

a. General form. Convening orders must be in official letter form, addressed from the CA to the senior member of a board or court or to the investigating officer (s) of a command or litigation-report investigation. When circumstances warrant, an investigation may be convened by oral or message order. Signed, written confirmation of oral or message orders must be issued in each case and included in the investigative report. Convening orders must: recite the specific purposes of the inquiry and contain explicit instructions about its scope; require findings of fact (it may, unless a litigation-report investigation is being convened, also require opinions and recommendations); and contain directions for complying with the Privacy Act, Article 31, UCMJ, section 0202 (coordinating with law enforcement authorities), and section 0220 (concerning statements about origin of disease or injury), as necessary.

0214 PROOF OF FACTS - STANDARDS OF PROOF

a. General. An administrative investigation need not be conducted in accordance with the formal rules of evidence applicable to courts-martial. It should use the most effective methods for collecting, analyzing, and recording all relevant information and should include in its investigative report any relevant matter that a reasonable person would consider to be believable or authentic.

b. Standards of proof

(1) Preponderance of evidence. Except for facts of which a court may take judicial notice, see M.R.E. 201 and 201a, MCM, an administrative investigation shall arrive at findings of fact only if supported by a preponderance of the evidence, more likely than not, unless a higher standard is required, as set forth below.

(2) Clear and convincing. This term means that the truth of the facts asserted is highly probable. To be clear and convincing, evidence must leave no serious or substantial doubt as to the correctness of the conclusion in the mind of objective persons, after considering all the facts. It is a higher degree than a preponderance of the evidence standard, but it does not require proof beyond a reasonable doubt as in criminal cases; see also paragraph 3 of Appendix A-2-a. Findings of fact relating to the following issues must be established by clear and convincing evidence:

(a) to rebut the presumption that an injury, disease, or death has been incurred in the line of duty;

(b) to rebut the presumption of mental responsibility when the question of a member is mental responsibility has been raised by the facts or by the nature of the incident;

(c) to rebut the presumption that an unauthorized absence period of less than 24 hours did not materially interfere with the performance of the member is military duties in line of duty/misconduct cases; or

(d) to find that the acts of a deceased service member may have caused harm or loss of life, including the member's own, through intentional acts.

(3) Inferences. An investigation may not speculate on the causes of an incident. Inferences drawn from evidentiary enclosures or personal observations, however, are permissible. For example, an investigation may determine, through tangible evidence, the likely chain of events relative to the subject of investigation. However, it is, in most cases, improper for an investigative body to theorize about the thought processes of an individual that resulted in certain courses of conduct.

c . Evidence

(1) Safekeeping

(a) To the extent consistent with mission requirements, the investigating officer and the CA will ensure that all evidence is properly preserved and safeguarded until the investigation is complete and all relevant actions have been taken. Perishable or unstable items of evidence, such as tire tracks, should be promptly photographed or otherwise preserved, preferably by trained personnel. Evidence should not be handled by untrained personnel, unless absolutely necessary to preserve its integrity.

(b) Original items with evidentiary value must be retained or adequate steps taken to ensure their safe storage. Operational commands are encouraged to make satisfactory storage arrangements with supporting elements ashore in this regard. The CA's forwarding endorsement must indicate where the evidence is maintained, what arrangements have been made for its safekeeping, and report the name and telephone number of the responsible official.

(c) For fungible items, chain-of-custody documents must also be preserved together with the evidence to which they relate. Consult a judge advocate for assistance. See OPNAVINST 5580. i (series) for further information; OPNAV Form 5527/11 is the "Evidence/Property Custody Receipt" form and includes space for chain-of-custody documentation.

(d) Failure to properly safeguard and account for evidence may result in its inadmissibility in subsequent legal proceedings and therefore prejudice the interests of the Government.

(2) Tangible evidence. Whenever the condition, location, or other characteristic of an item of tangible evidence has probative value, include the item or a photograph, description, chart, map, or suitable reproduction in the investigative report. Discretion, however, must be exercised in enclosing graphic photographs since doing so has significant potential for shocking the sensitivities of relatives and others to whom the investigation may ultimately be released. When including such materials, place them in a separate envelope marked: "CAUTION, CONTAINS GRAPHIC PHOTOGRAPHS. VIEWER DISCRETION WARRANTED."
If an investigator or board member observes an item and gains relevant sense impressions, e.g., noise, texture, smells, or any other impression not adequately portrayed by a photograph, chart, map, or other representation, the impressions should be recorded and included as an enclosure to the report.

(3) Documentary evidence. Documentary evidence includes records, logs, documents, letters, diaries, reports, and statements. Documents should indicate their source and specify any special restrictions on their disclosure to third parties. Originals or authenticated copies should be obtained when possible. Completion and forwarding of investigations will not be delayed to await final reports, originals, or similar documents unless their inclusion is absolutely essential to the completion of the investigative report. Instead, the unavailability of such items should be noted and the investigation completed and forwarded. Documents subsequently obtained shall be forwarded by separate correspondence, via the review chain, with appropriate reference to the report of investigation.

(4) Photographs. When photographs are included as part of the investigation, the following information should be included on the reverse side: the hour and date they were taken; a brief description of the location or area photographed; the full name and rank or rate of the photographer; and full names and addresses of persons present when the photographs were taken. If available, the photographer should be asked to provide details surrounding the taking of the photographs such as type of camera, distance from object, and so forth. Similar information should be on a label affixed to any videotape included in the investigation.

(5) Requests for preservation of aircraft wreckage following a crash. Immediately upon receipt, all requests for the preservation of aircraft wreckage will be forwarded to NAVAIR (Air 412). If available, the original request with any attachments should be forwarded. Copies of the forwarding letter and the original request with all attachments shall be forwarded separately to OJAG (Code 15).

d. Witnesses and warnings

(1) Witnesses not suspected of misconduct or improper performance of Duty:

(a) Command investigations. Ordinarily, witnesses should provide statements in informal interviews. They may be required, however, to provide recorded testimony under oath. Probing questions as to “who,” “what,” “where,” “when,” “how,” and “why” should be pursued. To avoid irrelevant material or omission of important facts, an investigator may assist a witness in preparing a written statement. When an investigator takes an oral statement, it should be reduced to writing and signed by the witness or certified by the investigator to be an accurate summary or verbatim transcript. Care should be taken to ensure that any statement is phrased in the actual language of the witness.

(2) Witnesses suspected of an offense, misconduct, or improper performance of duty. Ordinarily, an investigation should collect relevant information from all other sources before interviewing persons suspected of an offense, misconduct, or improper performance of duty. Also, prior liaison with the appropriate staff judge advocate is advised, to ensure investigators have coordinated with law enforcement officials and will not impede any criminal investigations into the same incident; see section 0202. Before the interview, military suspects must be advised of Article 31, UCMJ, warnings; see Appendix A-1-m. Civilian personnel offices should be consulted about applicable collective bargaining requirements before interviewing civilian employees suspected of misconduct.

0216 INVESTIGATIVE REPORTS

c. Preliminary statement

(1) A preliminary statement informs convening and reviewing authorities that all reasonably available evidence was collected or is forthcoming and each directive of the convening authority has been met. After setting forth the nature of the investigation, the preliminary statement details difficulties encountered, extensions requested and granted, limited participation by any member or advisor, and any other information necessary for a complete understanding of the case. The itinerary of an investigator or board in obtaining information is not required.

d. Findings of fact. Findings of fact must be as specific as possible as to times, places, persons, and events. Make each fact a separate finding, and cite the enclosure supporting each finding.

e. Opinions. Opinions are reasonable evaluations, inferences, or conclusions based on the facts found. Each opinion must cite the findings of fact upon which it is based. In the case of a litigation-report investigation, opinions shall not be expressed unless requested by the CA, or by the cognizant judge advocate.

f. Recommendations. Recommendations depend on the nature of the facts found and opinions expressed. Recommendations shall not be offered unless requested by the CA, or by the

cognizant judge advocate in the case of a litigation-report investigation. The CA or cognizant judge advocate may require recommendations in general or limited subject areas.

PART E -- LINE OF DUTY/MISCONDUCT

Section 0220 WHEN LINE OF DUTY/MISCONDUCT DETERMINATIONS ARE REQUIRED

a. General. If a member incurs a disease or injury that may result in a permanent disability or that results in the member's physical inability to perform duty for a period exceeding 24 hours, as distinguished from a period of hospitalization for evaluation or observation, then determining whether the disease or injury was incurred in the line of duty or as the result of misconduct is very important. An injury or disease suffered by a member of the Naval service will, however, be presumed to have been incurred in the line of duty and not as a result of misconduct, unless contrary findings are made.

b. Death cases. A line of duty determination is required whenever an active duty service member of the Naval service dies, in order to make decisions concerning eligibility and annuity calculations under the Uniformed Services Survivor Benefit Program; see Part F, section 0236 of this Manual.

0225 MENTAL RESPONSIBILITY

a. General rule. A member may not be held responsible for particular actions and their foreseeable consequences if, as the result of mental defect or disease, the member was unable to comprehend the nature of such acts or to control his actions.

b. Presumption. In the absence of evidence to the contrary, all members are presumed to be mentally responsible for their acts. If a question of the mental responsibility of a member is raised by the facts or by the nature of the incident, this presumption ceases and the investigation must clearly and convincingly establish the member's mental responsibility before an adverse determination can be made.

c. Suicide attempts and suicides. In view of the strong human instinct for self-preservation, suicide and a bona fide suicide attempt, as distinguished from a suicidal gesture, creates a strong inference of lack of mental responsibility. Self-inflicted injury, not prompted by a serious suicidal intent, is at most a suicidal gesture, and such injury, unless lack of mental responsibility is otherwise shown, is deemed to be incurred as the result of the member's own misconduct; see section 0236.

0226 INTOXICATION AN DRUG ABUSE

a. Intoxication. In order for intoxication alone to be the basis for a misconduct determination, clear and convincing evidence must show that the member was intoxicated sufficiently to impair the rational and full exercise of his mental or physical faculties at the time

of the injury and that the impairment was the proximate cause of the injury. Intoxication or impairment may be produced by alcohol, a drug, or inhalation of fumes, gas, or vapor.

b. Presumption

(1) In cases involving alcohol, it may be presumed that when a member has a blood-alcohol content of .10 percent by volume or greater, the member was sufficiently intoxicated to impair the rational and full exercise of his mental or physical faculties. This presumption is rebuttable but, if not rebutted, is of sufficient strength to provide clear and convincing evidence of the member is impairment. The presumption alone, however, does not establish anything about the proximate cause of the injury.

(2) For example, if a sailor is injured while driving with a voluntarily induced blood-alcohol content of .10 percent by volume or greater, then it may be presumed that the sailor was impaired due to intoxication to the extent that he could not fully exercise his mental or physical faculties at the time of the wreck. To find misconduct, however, it still must be shown that the resulting impairment was the proximate cause of the injury. Thus, if the accident were caused solely by the wrongdoing of another driver, then the sailor is impairment was not the proximate cause of the injury.

(3) Intoxication, as described in section 0226, may also be found when there is no blood-alcohol content measurement available or when it measures less than .10 percent by volume. In such cases, all relevant information concerning the member's condition at the time of the injury or incident should be considered.

0229 HOW LINE OF DUTY/MISCONDUCT DETERMINATIONS ARE RECORDED

d. Command investigations. A command must convene an investigation and make findings concerning misconduct and line of duty when --

(1) the injury was incurred under circumstances which suggest a finding of "misconduct" might result. These circumstances include, but are not limited to, all cases in which a qualifying injury was incurred –

(a) while the member was using illegal drugs;

(b) while the member's blood alcohol content was of .10 percent by volume or greater. This does not preclude the convening of an investigation if the blood-alcohol percentage is lower than .10, if the circumstances so indicate.

0232 CHECKLIST FOR LINE OF DUTY/MISCONDUCT INVSTIGATIONS

The following is a checklist of matters that should be included, as applicable, in any report of an investigation convened to inquire into and make recommendations concerning misconduct and line of duty under the provisions of this chapter.

a. Identifying information. The complete name, grade or title, service or occupation, and station or residence of all persons, military and civilian, killed or injured incident to the event under investigation; see section 0215 for advice required to be given by the Privacy Act if social security numbers are requested.

b. Facts. All facts leading up to and connected with an injury, disease, or death.

c. Records. Military or civilian police accident reports, pertinent hospitalization or clinical records, death certificates, autopsy reports, records of coroners' inquests or medical examiners i reports, and pathological, histological, and toxicological studies. If originals cannot be included, then the report shall state where the originals are located and the name and telephone number of the official responsible for their safekeeping.

d. Site of incident. Complete information concerning the site and terrain where the incident in question occurred as well as photographs, videotapes, maps, charts, diagrams, or other exhibits that may be helpful to a complete understanding of the incident. When photographs are included as part of the investigation, the following information should be included on the reverse side: the hour and date they were taken; a brief description of the location or area photographed; the full name and rank or rate of the photographer; and full names and addresses of persons present when the photographs were taken. If available, the photographer should be asked to provide details surrounding the taking of the photographs such as type of camera, distance from object, and so forth. Similar information should be on a label affixed to any videotape included in the investigation.

e. Duty status. Include all pertinent facts with respect to the duty, leave, liberty, or unauthorized absence status of an individual at the time of the incident.

f. Reserves. When the person involved is a member of a Reserve component of the Navy or Marine Corps, complete information as to the member is status in relation to extended active duty, active duty for training, or inactive duty training, or travel to and from such duty, at the time of the incident must be stated.

g. Injuries. Complete information as to the nature and extent of all injuries to Naval personnel and the place and extent of any hospitalization resulting there from. Include costs when civilian facilities are used. Also include the amount of "lost" time.

h. Impairment. Refer to section 0226 regarding applicable presumption. When relevant, evidence regarding the state of intoxication and the extent of impairment of the physical or mental faculties of any person involved and connected with the incident. Evidence as to the individual's general appearance and behavior, rationality of speech, coordination of muscular effort, and all other facts, observations, and opinions of others bearing on the question of actual impairment shall be obtained and recorded. Efforts shall be made to determine the quantity and nature of the intoxicating agent used and the period of time over which used by the person. Results of any blood, breath, urine, or tissue tests for the intoxicating agent should also be obtained and submitted as exhibits.

i. Mental competence. When material, evidence regarding the mental competence or impairment of the deceased or injured person. In all cases of suicide or attempted suicide, evidence bearing on the mental condition of the deceased or injured person shall be obtained. This will include all available evidence as to social background, actions, and moods immediately prior to the suicide or the suicide attempt, any troubles that might have motivated the incident, and any relevant medical or counseling information.

PART F - - SPECIAL CONSIDERATIONS IN DEATH CASES

0233 GENERAL

a. Special considerations. The circumstances surrounding the death of Naval personnel, or of civilian personnel at places under military control, may be recorded in a variety of ways, such as autopsy reports, battlefield reports, and medical reports. Investigations conducted pursuant to this Manual may also focus on such deaths and may incorporate other official reports as enclosures. Since reports pertaining to deaths of military members are by law generally releasable to family members, special considerations prevail in the investigation of death cases.

b. NCIS notification. NCIS must be notified of any death occurring on a Navy vessel or Navy/Marine Corps aircraft or installation, except when the cause of death is medically attributable to disease or natural causes.

c. Time limitations. The period for completing the administrative investigation report/record into a death shall not normally exceed 20 days from the date of the death, or its discovery. For good cause, however, the CA may extend the period. Requests and authorizations for extensions must be coordinated with the next reviewing authority. The CA and subsequent reviewers have 20 days to review and endorse the investigation. Noncompliance with these time requirements must be explained in the endorsement of the deviating command and commented upon by subsequent endorsers. See MILPERSMAN 1770-060 for the requirement to submit Status Investigation Reports.

d. Release of death investigations

(1) Policy for release to next of kin. As a normal rule, death investigations reports/records shall not be released to the public until they are final; see section 0219. In the interest of providing the decedent’s next of kin with timely information, however, it is DON policy that upon completion of the review by the first flag officer in the chain of command, the reviewer shall release an advance copy of the investigation, per a request, to the next of kin. The release of an advance copy to requesting next of kin shall be made unless release would violate law, e. g., investigation classified, or the endorser can articulate how release would harm the command’s mission, or would interfere with an ongoing criminal investigation, or why release should not be made for good cause. If an endorser does not wish to release an investigation to requesting next of kin, this decision shall be coordinated with OJAG (Code i3), at 703-604-8200/DSN 664-8200.

(2) Delivery to next of kin. In providing death investigations to the next of kin, consideration should be given to the potential impact of the report. Section 0240 directs that

graphic photographs are to be separately wrapped and labeled. Similar procedures should be employed for autopsy reports and other written materials containing graphic details of injury, wounds, mutilation, etc. In order to assist those who may still be grieving to understand the meaning and significance of the report of investigation, releasing authorities should ensure, when reasonable, hand delivery of the report by someone who can discuss it with the family. Normally, the Casualty Assistance Calls Officer(s) would make the delivery, but there may be reasons (technical subject-matter, personal friendships, etc.) for another individual to be assigned this task.

0234 WHEN INVESTIGATIONS OF DEATH CASES ARE REQUIRED

A preliminary inquiry, see section 0203, shall, as in any other circumstance potentially warranting an investigation, be conducted into the death of a member of the Naval service or into the death of a civilian aboard a place under Naval control. At the conclusion of the preliminary inquiry, the commander must determine which of the options listed in section 0204 will be exercised, and report that decision to the next superior in the chain of command; see section 0203h(2). Normally, a command investigation, or a limited investigation, will be appropriate to inquire into a death case that warrants investigation under the below guidelines. A court or ‘board of inquiry is appropriate in some cases, as discussed below. In deciding on the type and necessity of investigation, the commander shall consider the following:

a. No investigation required. An investigation under this Manual will normally not be conducted if the preliminary inquiry shows that the death:

(1) was the result of a previously known medical condition and the adequacy of military medical care is not reasonably in issue; or

(2) was the result of enemy action, but see subsection b(4) below.

b. Investigation required. An investigation under this Manual shall be conducted if the preliminary inquiry shows:

(1) the case involves civilian or other non-Naval personnel found dead aboard an activity under military control, where the death was apparently caused by suicide or other unusual circumstances;

(2) the circumstances surrounding the death place the adequacy of military medical care reasonably at issue;

(3) the case involves the death of a military member and a probable nexus exists to Naval service, except where the death is as a result of enemy action, see sections b(4) and (c) below; or

(4) it is unclear if enemy action caused the death, such as in possible “friendly-fire” incidents.

0238 INDEPENDENT REVIEW

a. General. To enhance the investigation process, prior to taking action on an investigative report which calls into question the propriety of a deceased individual's conduct, including all apparent suicide cases, the CA may cause the report to be reviewed by an individual not previously connected with the investigation process and outside the CA's immediate chain-of command.

b. Qualifications of reviewer. The individual selected pursuant to this section to review the preliminary report should, to the extent feasible, possess such training, experience, and background that he can critically analyze the salient circumstances surrounding the death as documented in the report. For example, if a pilot's death occurred as the result of an aircraft accident, then the individual selected should be a pilot. If, by way of further example, an enlisted Marine's death occurred as the result of an apparent suicide, then the individual selected should be a senior noncommissioned officer or company commander. In all cases, the individual selected should have no official or personal interest in the outcome of the investigation.

c. Duties of reviewer. The individual selected to review the investigative report shall not act as the deceased's representative, but should critically analyze the investigative report from the perspective of the deceased, tempered by the reviewer's own experience, training, and education. If, after conducting the review, the reviewer believes comment on the thoroughness of the investigation or the accuracy of its findings is warranted, then such comments shall be provided in writing to the CA. The review shall be completed within 10 working days of delivery of the report to the reviewer.

d. Action. The CA shall consider such comments as the reviewer may make and take such action as the CA deems warranted. The reviewer's comments, if any, shall be appended to the investigative report.

0239 STANDARD OF PROOF

To find that the acts of a deceased service member may have caused harm or loss of life, including the member's own, through intentional acts, findings of fact relating to those issues must be established by clear and convincing evidence; see Appendix A-2-a for a definition of that term.

OPNAVINST 5530.14D, "Navy Physical Security and Law Enforcement Manual," dated January 30, 2007

The objectives of this instruction are to establish policy for the safety and security of personnel and property; to provide guidance and set forth standards for military and civilian Navy personnel performing security and law enforcement duties; and protect Navy forces and assets from criminal activity.

Under Section 0607 - NSF Apprentice Training Standards, states the following:

a. NSF personnel will satisfactorily complete the training identified under Appendix B prior to being assigned security duties. Those skills below that are further annotated with Law Enforcement (LE) and Armed Sentry (AS) are only required for personnel performing law enforcement sentry duties. Personnel performing unarmed duties, e.g., unarmed vehicle inspector, are required to satisfactorily complete the skills training appropriate to their job requirements. Personnel required to be armed as a condition of employment are required to satisfactorily complete all AS annotated subjects.

b. This training may be accomplished via MA "A" School, local or regional security training academy, or a combination to meet the training requirements identified in Appendix B.

d. Apprentice Training Skills: See attached specific skill taskings documented within Appendix B.

Under Section 0608, Annual Sustainment Training, the following is prescribed:

a. NSF personnel will satisfactorily complete sustainment training for the skills listed in Appendix B. The frequency of the sustainment training is annotated for each skill using As Needed, Daily Guard Mount (DGM), Monthly (M), Quarterly (Q), Semi-annually (SA), or Annually (A).

c. Local and Regional training academies shall develop training addressing local policies and directives for incorporation into the standardized training curriculum.

d. Sustainment (Phase II) Training Skills: See attached specific skill taskings documented within Appendix B.

e. Failure to satisfactorily complete sustainment training by the anniversary of the initial or previous sustainment training will result in removal of the individual from assigned duties until such time that the training can be satisfactorily completed. Each standardized plan of instruction will contain the initial training, testing, remediation, and point of failure information.

OPNAVINST 5580.1A Navy Law Enforcement Manual, July 26, 2000

This regulation details procedures, provides guidance, and sets forth standards for military and civilian Navy personnel performing law enforcement duties; this instruction is not intended to create any rights, substantive or procedural; it does not place limits on the lawful prerogatives of Navy law enforcement personnel.

Under Section 0109. Training.

a. The training organization, Phase I, Phase II and in-service training are specified under reference (b). This training is mandatory and personnel will not be authorized to perform law enforcement duties without its satisfactory completion. Roll call is also a good forum for updating policy or conducting awareness training.

b. To ensure adequacy of training, each security department should have an active field training officer program. In addition, security officers will review training records quarterly to ensure all personnel have received required training and immediately schedule personnel who are delinquent.

OPNAVINST 5530.14D, "Navy Physical Security and Law Enforcement Manual," dated January 30, 2007

This regulation issues policy, identify responsibilities and set forth standards for security and law enforcement operations within the Navy. This instruction is not intended to create any rights, substantive or procedural; it does not place limits on the lawful prerogatives of Navy security and law enforcement personnel. Under paragraph 607(a), NSF Apprentice Training Standards it states, "NSF personnel will satisfactorily complete the training identified prior to being assigned security duties."

Under paragraph 607(b), it states, "This training may be accomplished via MA "A" School, local or regional security training academy, or a combination…."

Commander Navy Region Mid-Atlantic (COMNAVREG MIDLANT) 5500.2, "Regional Physical Security Standard Operating Procedures," undated

This regulation identifies standard operating procedures for the MIDLANT Physical Security Departments. Under Section 9-1 Mission, paragraph 1, it states the training department mission is "To provide basic Force Protection and advanced Law Enforcement and Phase II training, maintain and enhance the current level of security training to personnel of the Region's Naval Security Force (NSF)."

NCIS 3, Criminal Investigations, Chapter 30.

This chapter provides policy and procedures for investigating deaths. Under paragraph 30-5.6

> Death investigations involving on-base incidents of reported suicide and other self-inflicted incidents (e.g., autoerotic deaths) will be pursued with the same intensity and coverage as known homicides following the appropriate provisions of sections 30-6., 30-27.6. and 30-27.9. Telephonic contact is encouraged between the case agent and the NCISHQ review desk, as such investigations must be reviewed in detail by NCISHQ for potential briefings to the Department of Defense Inspector General (DoD/IG), congressional committees, and families of the deceased.

Under paragraph 30-6.2

> Because staging the death of another person is possible (i.e., making a situation appear to be an accident or suicide), homicide should not be ruled out by an investigator as a consideration, regardless of how obvious it appears that the death scene may point to an alternative manner of death. All medically unattended deaths are to be presumed homicides until investigation proves otherwise, thus preventing destruction or loss of valuable evidence at the scene and loss of important information from witnesses. All logical leads developed and pertaining to any manner of death should be pursued and documented completely. Any evidence of foul play must be further investigated and resolved if possible; contradictory information should be clarified before the close of the investigation. To the extent possible, all discrepancies received from persons interviewed should be resolved through re-interviewing and other appropriate means, since a single interview with persons having pertinent knowledge of the death may not be sufficient and complete. For example, if two people discover a body at the same time yet the details of the discovery differ considerably upon initial interviews with each of the individuals, re-interviews are necessary to resolve major discrepancies in the given accounts. The process

of re-interview and thorough documentation minimizes doubt regarding the investigative result, as well as the cause and manner of death.

Under paragraph 30-13

SUICIDE. SECNAVINST 5430.107 series directs that a NCIS investigation will be conducted regarding the unattended death of military personnel, dependents, or DON employees occurring on a Navy or Marine Corps installation where criminal causality cannot be firmly excluded. In all instances of unattended death on a Navy or Marine Corps installation or vessel, the possibility of foul play always exists. Therefore, NCIS should conduct an investigation even in those instances where the death appears from the outset to have resulted from suicide.

NASB Standard Operating Procedures (SOP), 2005

These procedures supplement COMNAVREG MIDLANT and OPNAV policies. This SOP provides training requirements for civilian and military personnel who are members of the NASB Security Department. We reviewed the SOP and provided the applicable tasks pertinent to our review.

SOP – T-001 (Training Requirements) - The new hires will attend the Security Reaction Force-Basic (SRF-B) academy.

b. In-service training

1) Phase II

a) Minimum maintenance of training standards is essential to enable security force personnel to perform their duties.

b) Phase II training will be conducted annually for all security force personnel in accordance with ref (b). Phase II training is mandatory and personnel will not be authorized to perform law enforcement duties without its satisfactory completion.

c) Periodic review of instructional material and instructor's presentations shall be conducted to determine how effectively they meet security force training requirements.

SOP – T- 2 (Training Administration) - Training jackets will be created for all members and employees of NASB Police Precinct.

B. Required monthly reports and schedules

1) Monthly training schedule. The monthly training schedule will be drafted by the Training Officer and forwarded to the chain of command by the 15th of the month. Upon approval the training schedule will be posted on the training board located in the training classroom.

2) Job Qualification Requirement (JQR) delinquency report. The JQR delinquency report will be drafted by the section FTO and forwarded to the Training Officer and the Operations Commander by the first working day of the month.

3) Monthly section training reports. Section training reports will be completed by the section FTO and forwarded to the Training Officer and the Operations Commander by the first working day of the month.

4) Regional monthly report. Information for the regional report is due to the Leading Chief Petty Officer (LCPO) by the first working day of the month. The Training Officer is responsible to provide the information.

5) Quarterly training record verification. The training record report will be completed by the Field Training Officer after all records have been reviewed for the quarter. The report will list any delinquent qualifications/record entries. The report will be forwarded to the Training Officer by the first working day of the month.

6) Yearly training schedule. The yearly training schedule will be completed and forwarded annually to the chain of command no later than 01 July. The plan will include the following: SRF-B academies, phase II, drills and any other training dictated by the chain of command.

Appendix B. Phase I Skills & Phase II Police Officer/Master-at-Arms Sustainment Training

Apprentice Training (Phase I) Skills:

(1) Administration
- (a) Overview/Orientation.
- (b) Security Unit Duties and Functions.
- (c) Standards of Conduct.
- (d) Forms and Reports/Report Writing.
- (e) Area Familiarization/On-Job-Training/as appropriate to the job assignment.

(2) Antiterrorism
- (a) AT Level I.
- (b) Vehicle and Personnel Movement Control.
- (c) Threat Spectrum
- (d) Force Protection Conditions and Measures.
- (e) Physical Security Safeguards.

(3) Legal Subjects
- (a) Jurisdiction and Authority.
- (b) Search and Seizure.
- (c) Uniform Code of Military Justice.
- (d) Self-Incrimination/Admissions and Confessions.
- (e) Apprehension versus Arrest.
- (f) Legal Testimony: Captain's Mast/Courts Martial.

(4) Traffic Laws and Enforcement
- (a) Traffic Control.
- (b) Random Vehicle Inspection.

(5) Patrol
- (a) Crime Scenes/Preservation of Evidence
- (b) Watch Standing Procedures
  - -1 . Sentry, Entry Control Point.
  - -2. Vehicle/Pleasure Craft/Other Vessel Inspection.
  - -3 . Situational Awareness
  - -4. Incident Reporting
  - -5 . Interpersonal Skills.
  - -6 . Information Gathering.
- (c) Tactical Communications.
- (d) Illegal Drug Identification.
- (e) Mobile Patrol Procedures, Vehicle & Boat .
- (f) Vehicle Stops/Search of Vehicles.

(6) Other Security Events

(a) Crowd Control

(b) Preplanned Response Procedures (Bomb Threat, Small Boat Attack, Suspicious Package, etc.).

(7) Professional Skills

(a) Weapons Qualifications.

(b) Use of Force Continuum.

(c) Physical Control Techniques.

(d) Approved Non-lethal weapons training as stipulated and limited in the following paragraph, including, but not limited to baton, defensive sprays (contamination required for initial training) and handcuffs/flex cuffs.

(e) Cardiopulmonary Resuscitation (CPR).

(f) First Aid (First Responder).

(g) Emergency Vehicle Operations.

(h) Physical Fitness.

Annual Sustainment (Phase II) Training - NSF personnel will satisfactorily complete sustainment training for the skills listed below. The frequency of the sustainment training is annotated for each skill using As Needed, Daily Guard Mount (DGM), Monthly (M), Quarterly (Q), Semi-annually (SA), or Annually (A). Personnel performing unarmed sentry duties, e.g., unarmed vehicle inspector, are required to satisfactorily complete sustainment skills appropriate to their job requirements.

(1) Administration

(a) Changes in SOP, Post Orders, etc (as needed).

(b) Standards of Conduct (A).

(2) AT Level I

(3) Legal Subjects

(a) Jurisdiction and Authority (A).

(b) Search and Seizure (A).

(c) Uniform Code of Military Justice (A).

(d) Self-Incrimination/Admissions and Confessions

(e) Apprehension versus Arrest (A)

(f) Legal Testimony: Captain’s Mast/Courts Martial (as needed).

(4) Traffic Laws and Enforcement

(a) Traffic Control (A).

(b) Random Vehicle Inspection (A).

(5) Patrol

(a) Crime Scenes/Preservation of Evidence (SA).

(b) Watch Standing Procedures (DGM).

-1. Sentry, Entry Control Point.

-2. Vehicle/Pleasure Craft/Other Vessel Inspection.
-3. Situational Awareness.
-4 . Incident Reporting.
-5. Interpersonal Skills.
-6. Information Gathering.

(c) Tactical Communications (A).
(d) Drugs of Abuse Identification (A).
(e) Mobile Patrol Procedures, Vehicle & Boat (Q).
(f) Vehicle Stops/Search of Vehicles (Q).

(6) Other Security Events

(a) Crowd Control (As needed /A).
(b) Preplanned Response Procedures (Bomb Threat, Small Boat Attack, Suspicious Package, etc.) (M).

(7) Professional Skills

(a) Weapons Qualifications (SA).
(b) Use of Force Continuum (DGM).
(c) Physical Control Techniques (Q).
(d) Approved Non-lethal weapons training as stipulated and limited in the following paragraph, including, but not limited to baton, defensive sprays (contamination required for initial training) and handcuffs/flex cuffs (SA).
(e) CPR (A).
(f) First Aid (First Responder) (A).
(g) Emergency Vehicle Operations (A).
(h) Physical Fitness

Appendix C. Management Comments

Assistant Secretary of the Navy, Manpower & Reserve Affairs Comments

DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

5830
24 Sep 10

From: Assistant Secretary of the Navy, Manpower & Reserve Affairs
To: Department of Defense Inspector General

Subj: REVIEW OF MATTERS RELATED TO THE DEATH OF HOSPITALMAN (HN) CHRISTOPHER PURCELL, USN (PROJECT NO. 2009C002)

Ref: (a) DODIG memo of 6 Aug 10

1. Per reference (a), the draft report has been reviewed. The Navy concurs with the findings and recommendations of the draft report as it pertains to the deficiencies in the line of duty investigation of HN Purcell. The Bureau of Medicine and Surgery (BUMED) has directed Navy Medicine East to reopen and complete the investigation in a manner consistent with the draft report. The revised investigation is due to BUMED no later than 20 October 2010. BUMED will review and respond by 29 October 2010.

J. M. GARCIA

Copy to: Naval Inspector General

Appendix D. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense for Personnel and Readiness
General Counsel, Department of Defense

Department of the Navy

Secretary of the Navy
Naval Inspector General*
Commander, Navy Region Mid-Atlantic*
Chief, Navy Bureau of Medicine and Surgery*
Director, Naval Criminal Investigative Service*
Commanding Officer, Naval Air Station Brunswick
Commanding Officer, Navy Medicine East
Commanding Officer, Naval Health Clinic New England

Congressional Committees and Subcommittees, Chairman and Ranking Minority Member

Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Governmental Affairs
House Subcommittee on Defense, Committee on Appropriations
House Committee on Armed Services
House Committee on Government Reform

*Recipient of draft report

Inspector General
Department of Defense